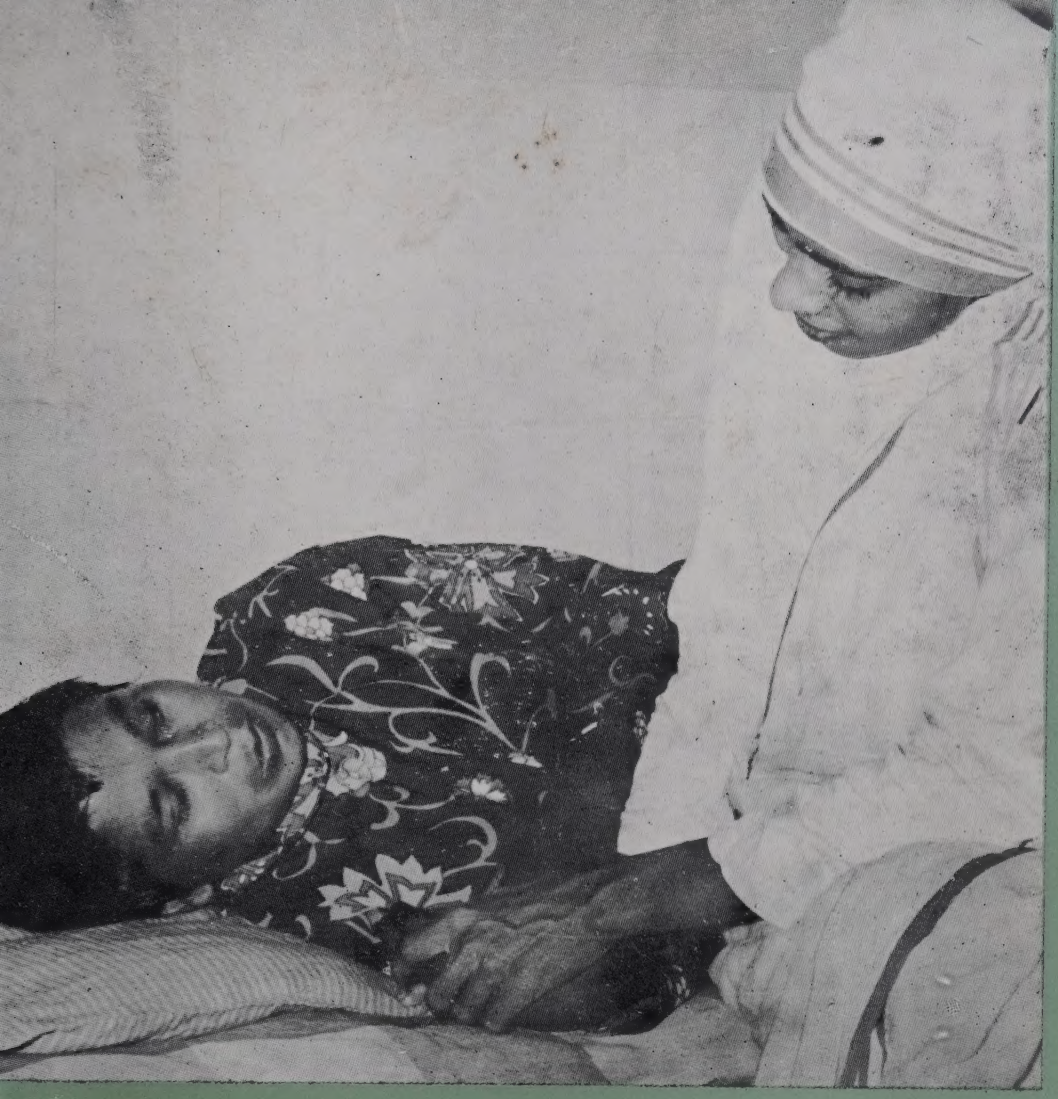

NATIONAL
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1981

MEETING DISABILITIES A CHALLENGE

OCTOBER
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nirmala college ranchi

SIEMENS

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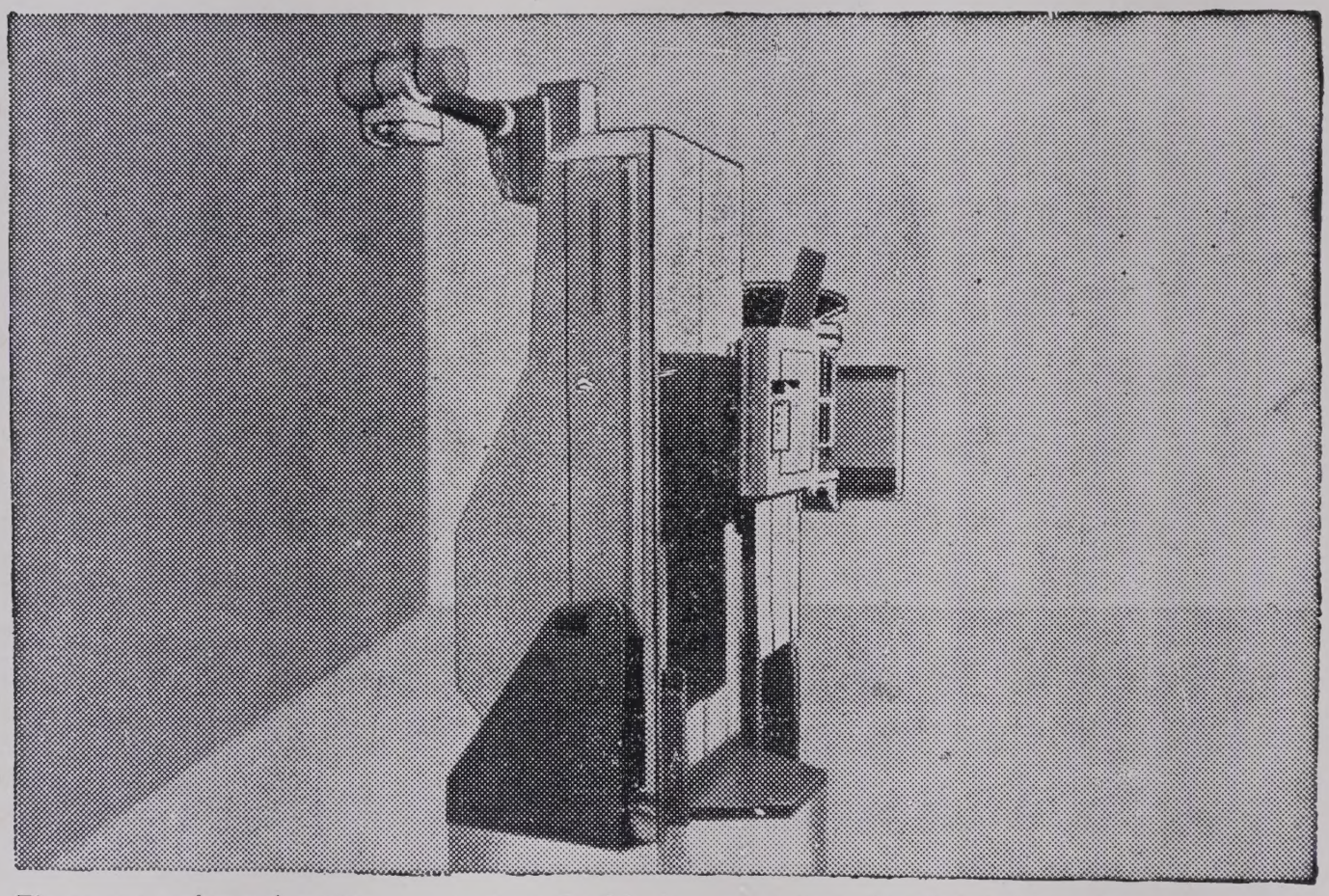

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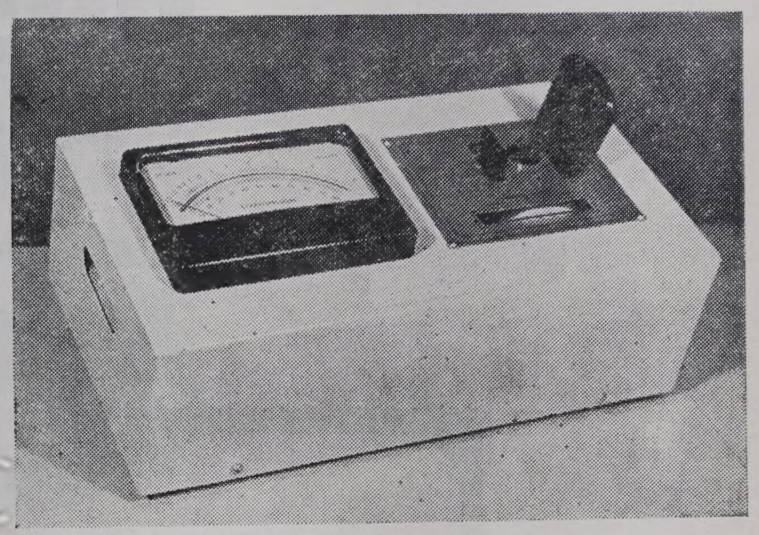

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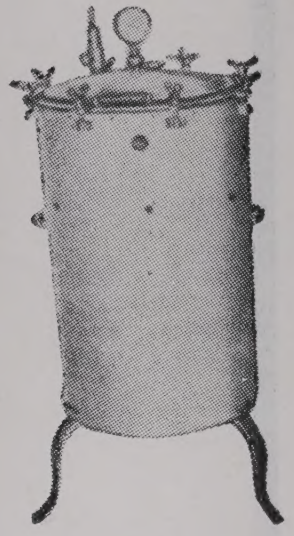

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Tel. 616521
September 22, 1981

MESSAGE

To the Catholic Hospital Association of India, of which I was happy to make the acquaintance as soon as I started my mission among you;

and to each one of its numerous member institutions, which are present as signs of love and development in the cities and rural areas of this great Country;

and especially to all my dear Brothers and Sisters who bear witness to the charity of Christ and of his Church through their generous response to their apostolic call on behalf of the suffering people of India, in fidelity to Catholic principles and openness to new challenges,

I express my sincere esteem and deep appreciation, my fraternal encouragement and cordial best wishes, praying for the continued success of their noble undertakings, and invoking upon them the abundance of God's choicest blessings.

New Delhi, September 14, 1981.

+ Agostino Cacciavillan
Apostolic Pro Nuncio
Sd/-

PRIME MINISTER'S OFFICE

New Delhi-110011
September 17, 1981

Rev. Fr. John Vattamattom, SVD,
Executive Director,
The Catholic Hospital Association
of India,
C.B.C.I. Centre,
Goldakkhana,
NEW DELHI-110001

Dear Sir,

The Prime Minister sends her good wishes for the success of the Convention which is being organised to discuss the theme "Meeting Disabilities—A Challenge".

Yours faithfully,
Sd/-
(U.C. Tiwari)
Addl. Information Adviser

Minister of
HEALTH AND FAMILY WELFARE
INDIA
NEW DELHI-110011

MESSAGE

I am very happy to know that the Catholic Hospital Association of India is organising its annual Convention this year at Ranchi from 23rd to 26th October, 1981.

Voluntary Associations have an important role in our society. Tremendous progress can be made in health care activities through their help in augmenting the facilities for the community. The services rendered by Catholic Hospital Association of India have always been well recognised.

I also feel happy to learn that the theme chosen for the Convention is "Meeting Disabilities—A Challenge". This is quite appropriate in the year of the Disabled.

NEW DELHI :
August 3, 1981.

Sd/-
(B. Shankaranand)

RAJ BHAVAN
PATNA-22

September 10, 1981

Message

Health care is one of our National priorities. I am, therefore, happy to know that the Catholic Hospital Association of India is playing a significant role in providing medical relief and health services to the people who are in need and distress, thus creating a sense of social responsibility and commitment to the welfare of the people and ensure progress of the country.

On this occasion when the 38th Annual Convention and Exhibition of Catholic Hospital Association of India is going to be held at Ranchi, I hope the members of this organisation would rededicate themselves for the noble cause of service and welfare of the under-privileged Sections of the society, irrespective of caste, creed and faith. I hope the deliberations at the Annual Convention would help to enlarge the scope of medical relief and health services for the benefit of larger number of people specially the poorer and weaker section of the Society.

I wish all success to the participants and Organisers of the Convention and the Exhibition.

Sd/-
(A.R. KIDWAI)
Governor of Bihar.

Dr. UMESHWAR PRASAD VERMA, D. Litt.
Minister
HEALTH & FAMILY WELFARE
BIHAR

MESSAGE

Dear Fr. Vattamattom,

I am glad that the Catholic Hospital Association of India is holding its 38th Annual Convention & Exhibition on the 23rd of October, 1981 at Ranchi. The Catholic Hospital Association is a well organised and united organisation to provide medical relief and combat the health hazards of the suffering humanity.

The Association by its various activities is rendering valuable health services particularly to the poor and the needy. The Catholic Association has a charitable character organised and directed towards extending health facilities to the teeming millions—activities which can be called Godly.

I wish the Convention all success.

Yours sincerely,

Sd/-

(Dr. Umeshwar Prasad Verma)

Fr. John Vattamattom, SVD
Executive Director,
The Catholic Hospital Association of India,
C.B.C.I. Centre
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MOST REV. BENEDICT MAR GREGORIOS,
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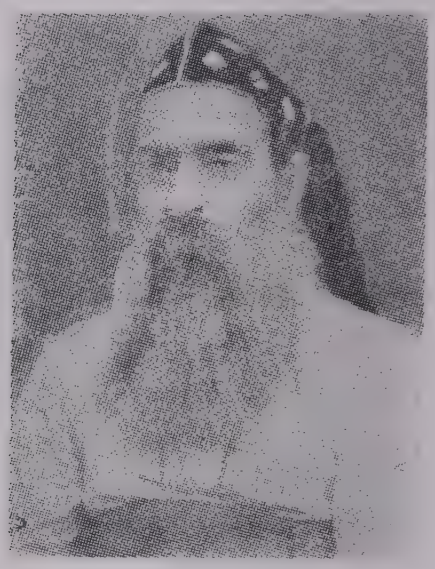

MESSAGE

The Divine Master showed a marked predilection to the blind, the lame, the deaf and the other disabled. He even deliberately pointed out this predilection as the sure sign of His divine mission. As the humble desciples of this great Master, we can do no better than to imitate this sublime model; nor can we bear a more convincing witness to the people around us, for the Christian message, than by placing ourselves at the service of the disabled and the dis-inherited.

If this should be our habitual attitude and our accepted programme of action, we should take as a special challenge, the proposal of the United Nations Organization, to observe 1981 as the International Year of the Disabled Person. In all humility, we should consider this as a providential reminder of our Christian duty. Let us be in the forefront in carrying out this noble programme. Let us declare our solidarity with every initiative in this field, from whatever quarters it may come. With the technical progress that has been made, especially in recent days in the art of healing and the vast experience available in this field, much can be achieved by organized effort and action.

I congratulate the Catholic Hospital Association for taking the theme for this years Convention "Meeting Disabled: A Challenge". I wish and pray that this Convention may enable the Church in India to add a new and brilliant chapter to her history of serving humanity and bearing witness to Christ—the Compassionate and the Merciful.

Sd/-
Archbishop of Trivandrum.

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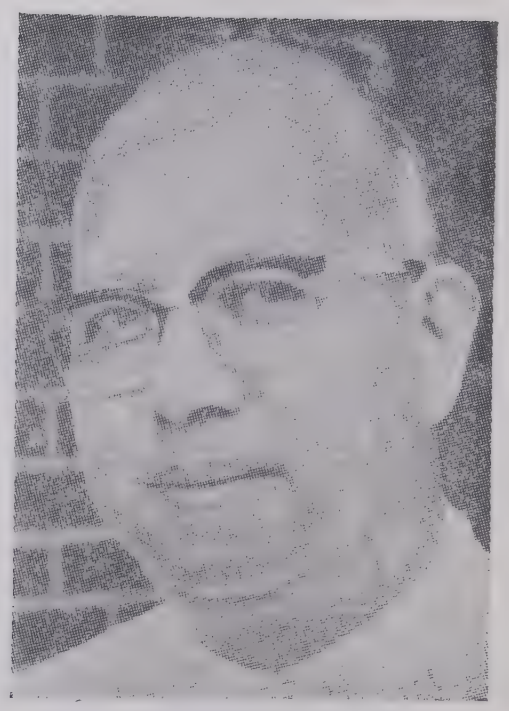

Dear Father John,

Your choice of Ranchi for the venue of the forthcoming Convention of the Catholic Hospital Association of India has brought me surprise as well as joy! Surprise because compared to many other dioceses which are well developed and whose history goes back to the hoary past, Ranchi is but a child of yesterday, having nothing worthwhile to say or show.

One thing, however, in favour of Ranchi is that it is an important centre of Catholic life in North India. From it have grown out the dioceses of Rourkela, Raigarh, Jamshedpur, Daltonganj and Ambikapur. Thousands have migrated to the sub-Himalayan tea gardens and from there the bulk of the Catholic population in the Dioceses of Darjeeling, Jalpaiguri, Tezpur and Dibrugarh. Thousands again are to be found in the big cities of Jamshedpur, Calcutta, Patna, Dhanbad and Delhi. Increasing numbers are finding work in the Industrial and mining centres of Madhya Pradesh and Orissa. A very large number, enough to make a diocese of some 13000, have crossed over to the Andaman and Nicobar Islands. Wherever they have gone they have carried along their Faith with them.

Yet another form of dispersal is the increasing numbers of vocations going out of Ranchi and its daughter dioceses particularly to the dioceses of North India. Quite a few are missionaries abroad in East Africa, South Sudan, Zaire and practically wherever the Missionaries of Charity of Mother Theresa and Brother Andrew are working.

We are grateful to CHAI for the encouragement it gives us by choosing Ranchi as the venue of its Convention. We on our part will pray and collaborate for its success and taking inspiration from it, will dedicate ourselves with greater zeal to the mission of healing and promoting the joy of good health among the people under our pastoral care.

May God bless the endeavours of CHAI and may the salubrious October weather of Ranchi help you to put in a very fruitful work is my cherished wish and blessing!

Rev. Fr. John Vattamattom SVD
Catholic Hospital Association of India
C.B.C.I. Centre
NEW DELHI-110001.

Yours sincerely in Christ,
Sd/-
(+ P. Kerketta, S.J.)
Archbishop of Ranchi.

VOLUNTARY HEALTH ASSOCIATION OF INDIA
C-14, Community Centre,
Safdarjung Development Area,
New Delhi-110016 India
Telephones : 652007, 652008
Gram : "VOLHEALTH" New Delhi-110016

September 25, 1981

MESSAGE

The members and staff of the Voluntary Health Association of India are happy with the Catholic Hospital Association on this joyful occasion, their convention, Ranchi, 1981.

Your theme, "Meeting Disabilities : a Challenge", expresses your unity with the whole world, who this year are stimulating concern for this particular section of our human family.

Progressively, C.H.A.I. is accepting community health as an ideal. This is closely associated with concern for the disabled, because preventable illnesses are a hazard to the disabled as they are to any other people. Disabled people are also members of their community, and in a positive way, healthy community benefits the disabled persons in the community.

Closely allied to community health, and pushing its potential still higher, is holistic health. The goal of holistic health is a high level of wellness in all the aspects of the human person, then reaching out to the community.

This goal is also related to the theme, and is deeply appropriate as a goal for the Catholic Hospital Association. Holistic health, in addition to physical, promotes psychological and spiritual health as well.

We congratulate C.H.A.I. for broadening its scope from hospital buildings to building communities, and from building communities to promoting, enlarging and improving the Kingdom of God.

Sd/-
(James Tong, S.J.)
Executive Director

Christian Medical Association of India

NAGPUR

COMMUNITY HEALTH CELL
326, V Main, I Block
Koramangala
Bangalore-560034
India

GREETINGS

The Christian Medical Association of India sends its greetings to the Catholic Hospital Association of India as it conducts the National Hospital Convention and identifies with it, sharing the aspirations to promote health in the community.

The Convention will bring together many who are committed to the task of helping others, that they may have health and abundant life.

As they come together and plan for the years ahead, the Christian Medical Association of India wishes to collaborate with the plans formulated.

May God bless the deliberations.

Sd/-
D. ISAAC
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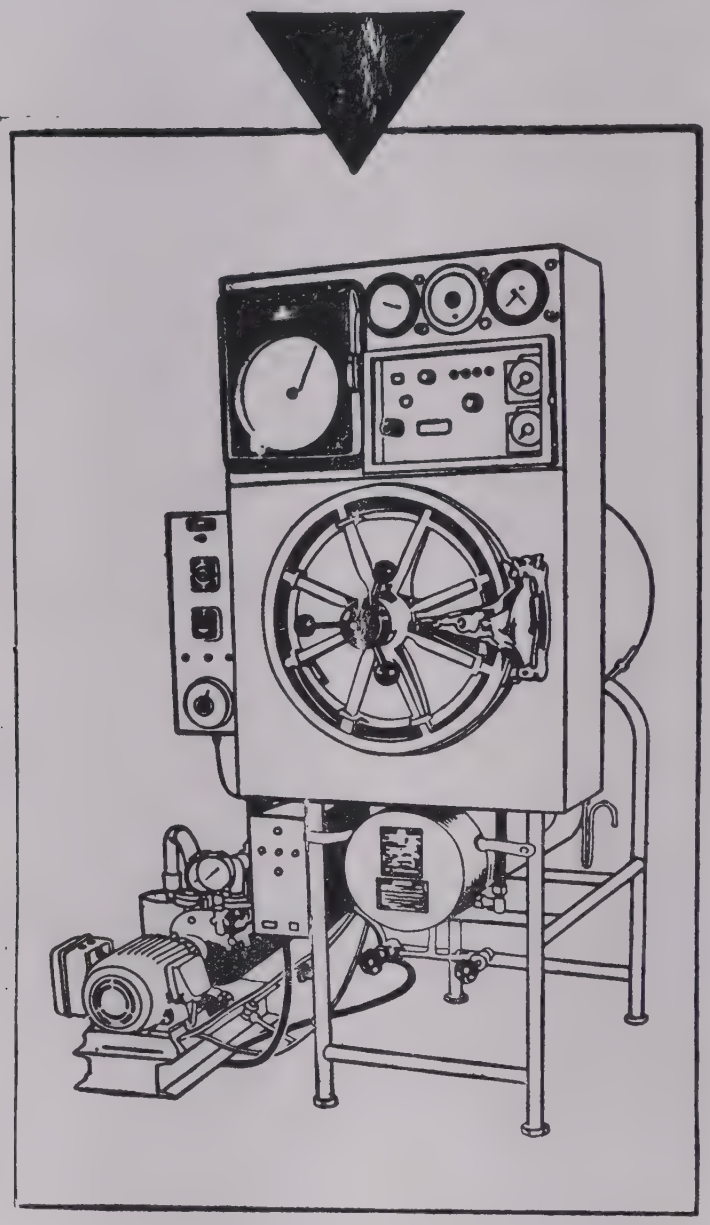

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NATIONAL HOSPITAL CONVENTION & EXHIBITION

October 23-26, 1981

THEME :

Meeting Disabilities A Challenge

●

EDITORS
Fr. John Vattamattom SVD
Varghese J Mulanjanany

●

COVER
P.M. Isaac, Bangalore

●

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CONTENTS

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meeting disabilities a challenge

fr john vattamattom svd

WITH the declaration of 1981 as the year of the disabled persons, by the United Nations, human history has been marked with a new sign—a sign of hope for the under privileged and the usually uncared for ones in the world. This has come at a time when there is an ever growing consciousness about social justice all around. Whether appropriate action is taken to bring about this question of justice is a different matter. However, the United Nations' aim is to focus attention on issues that are of paramount importance in the society. It was this concern for the vulnerable sections of the community that prompted the United Nation to declare the International Women's year, then the Year of the Child and now the Year of the Disabled persons. The question to be asked is, will these remain at the level of the slogan or will they go beyond? And that is perhaps the challenge before any one who is concerned about people and their growth towards the full maturity in the universal brotherhood under the Fatherhood of God. But the danger is there that some times we remain at the level of slogans, declarations and celebrations and fail to bring about lasting changes. It is against this back ground that we will have to see our role in meeting disabilities. It is a challenge only for those who believe in the under privileged common man who have to be masters of their own destiny. For others it becomes a programme to be carried out and the under privileged become the 'ever so grateful beneficiaries.'

From the very beginning the Church welcomed wholeheartedly the United Nations initiative of proclaiming the Year of the Disabled Persons. Celebrating the Day of Peace at the beginning of the year, the Holy Father expressed his great concern about the disabled persons and called upon all to pay special attention to solving their problem. "If only a minimum part of the budget," said the Pope, "for the arms race were assigned for this purpose, important successes could be achieved and the fate of many suffering persons alleviated." The Church's concern is further expresssed in the document from the Holy See for the International Year of the Disabled persons, of March 4, 1981, giving basic principles and operative guide-lines. Let me quote only the four main principles along which all our actions in meeting the disabilities should be directed.

1. Disabled person (whether the disability be the result of congenital handicap, chronic illness or accident, or from mental or physical deficiency, and whatever the severity of the disability) is a fully human subject, with the corresponding innate, sacred and inviolable rights.
2. Since the person suffering from handicap is a subject with full rights he or she must be helped to take his or her place in society in all aspects and at all levels, as far as is compatible with his or her capabilities.
3. The quality of a Society and a civilization are measured by the respect shown to the weakest of the members.
4. The fundamental approach to the problems connected with the sharing by the disabled in the life of society must be inspired by the principles of Integration, Normalization and Personalisation.

These are clearcut principles which leave no room for any speculations or personal interpretation and which need to be adhered to fully by any one who deals with disabled persons in whatever capacity.

Then comes the whole aspect of disability prevention. While proper rehabilitation of the disabled persons is of great importance, it is of greater importance to pay attention to prevention of disabilities. "Prevention is better than Cure" is an old adage yet it is very meaningful. When we analise the cases of nearly 500 million disabled persons in the world today and the causes of these disabilities, we should be shocked to see that barring a small percentage most of these cases could be prevented if only proper actions were taken in time. According to WHO study 19.3% of disabilities are caused by malnutrition alone. Perhaps this percentage will be much higher in the case of disabled person in India. Thousands of our innocent children are going blind every year due to malnutrition. Can something be done to remedy such an appalling situation? It is not just the problem of the medical field. It is a human problem. The whole problem of disability prevention should be viewed in the 1st place as a human problem and solutions should also be found in the human level. No such problems can be considered as an isolated issue. All are inter-linked very closely—in the economical, political, social, emotional, psychological and spiritual spheres. For example, taking the question of malnutrition alone, producing more food is no guarantee that all will have enough to eat. In our own country, we can have a false sense of pride telling we are in a position even to export food to other countries. But at the same time we can forget that 48% of our people are living below poverty line or millions are going hungry every day. It only shows that production of 'surplus' food does not guarantee a just distribution system or purchasing power for the under-privileged. For fear of being lengthy, I shall not go into further details. All what we need is to put the things in the right perspective. Any type of disability prevention can only be achieved by the concerted efforts of every one concerned, going beyond any type of group solidarities, discriminations or unhealthy competition, taking into account at the same time all aspects of the life of the people. Here it is imperative, particularly in a country like India, that the Government and voluntary agencies work hand in hand. Only then such a great challenge of meeting disabilities, whether by prevention or by rehabilitation, can effectively be met. Health care institutions too have a great responsibility in this regard. Let us all pool our resources, plan our actions and prepare ourselves better to meet this big challenge.

'IF'

By the Unknown Spastic

If you can keep your head when all about you,
are patting it as if you were aged two :

If you can trust your limbs when others doubt you,
accept help with good grace, not as your due;

If you can be content with your low earnings,
while others round have so much more to spend;

If you can learn to conquer normal yearnings,
to 'Sublimate' and not go round the bend;

If you can walk in crowds and keep your balance,
or talk with kings and not let speech be slurred :

If, when they praise some very minor talents,
you can let your real achievements go unheard;

If you can keep your dignity on falling,
get up to face the stars with a smile;

If you can bear the welfare workers calling
to tabulate you nearly in their file;

If you can face your limitations squarely,
yet keep on striving to the bitter end;

You will be more than just a spastic,
clearly, you'll be a miracle, my friend.

(Courtesy : CONTACT No. 61, April, 1981)

"Right from the moment of our birth, we are under the care and kindness of our parents. Then, later on in life, when we are oppressed by sickness and become old, we are again dependent on the kindness of others. Since it is the case that at the beginning and end of our lives we are so dependent on others' kindness, how can it be that in the middle we neglect kindness towards others?"

His Holiness the XIV Dalai Lama

THE INTERNATIONAL YEAR OF DISABLED PERSONS

By

STUART J. KINGMA

THE United Nations' Organizations have designated 1981 as the International Year of Disabled Persons. Individuals and organizations around the world are mobilizing to respond to this initiative on behalf of those 500 million members of the human family who, every day, carry with them some form of impairment or disability. The changes we are all looking for are fundamental, pervasive and far-reaching. The accomplishment of these changes will require a solid commitment on the part of everyone. All of us need to begin by understanding much more clearly what the nature of physical and mental impairment really is, what the full range of effects these impairments have upon the lives of those who have disabilities, and what is needed to permit disabled people to participate fully in their own lives and within family and society.

All these need to begin with an educational process. Architectural change is another part of the process, to permit people with disabilities to have free access to buildings and services. The prevention and treatment of impairment require much greater emphasis within all of our programmes, and particularly those related to the healing professions. Rehabilitation is another critical activity which will demand a new and creative approach if its services are to be made available to all of those who could benefit from it.

It may be helpful to begin with a few definitions. The following formulation is taken from a recent document of the World Health Organization (WHO) "*International Classification of Impairments, Disabilities, and Handicaps (1980)* :"

1. **Impairment** In the context of health experience, an impairment is any loss or abnormality of psychological, physiological or anatomical structure or function. An impairment may be temporary or permanent, and it includes the existence or occurrence of an anomaly, defect or loss in a limb, organ, tissue, or other structure of the body, or a defect in a functional system or mechanism of the body, including the systems

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of mental function. An impairment may cause functional limitations which are the partial or total inability to perform those activities usually carried out by the organ or systems affected. In principle, impairments represent disturbances at the organ or system level.

2. **Disability** In the context of health experience, a disability is any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being. This is concerned with compound or integrated activities expected of the person or of the body as a whole, such as are represented by tasks, skills and behaviours. Disabilities thus represent disturbances at the level of the person. In this connection, it is preferable to say that someone has a disability, a statement which preserves neutrality and implies that persons' potential still being possible. To say that someone is disabled risks describing the individual with a more pervasive concept and stigma.

3. **Handicap** In the context of health experience, a handicap is a disadvantage for a given individual, resulting from an impairment or a disability, that limits or prevents the fulfilment of a role that is normal (depending on age, sex, and social and cultural factors) for that individual. A handicap is thus a social phenomenon, representing the social and environmental consequences for the individual, stemming from the presence of impairments and disabilities.

The ideas and concepts just described can be linked in the following manner:

Disease or Disorder (intrinsic situation)	Impairment (exteriorized)	Disability (objectified)	Handicap (socialised)

Many factors play important roles in the origin of an impairment and its resulting functional limitation and disability. These causative factors include specific medical causes related to the individual, environmental factors, attitudes and other socio-cultural determinants and social demands. Table 1 below is an estimate provided by the WHO of the causes of disability and the estimated number of disabled people, by cause, in the world.

Interventions aimed at reducing the occurrence of disability or at diminishing its impact fall into two main categories which can be termed "disability prevention" and "rehabilitation". The *prevention of disability* includes a variety of activities including those which act upon the individual directly (treatment, counselling, prosthetics, medical care, training, etc.), those which act upon the individual's immediate surroundings (family, community, employer attitudes and behaviour towards the individual, etc.) and those with the broad aim of reducing risks occurring in society as a whole. *Rehabilitation* is usually defined as the third phase in medicine (prevention being the first and curative care the second), and this term is used to define such interventions as in general aim at providing treatment and services to patients who are already disabled or at great risk of disablement because of an existing functional limitation. It is "the combined and coordinated use of medical, social, educational and vocational measures for training or retraining the individual to the highest possible level of functional ability."

An analysis of the current situation allows us to make certain statements about future trends in the magnitude and characteristics of the disability problem. Again, I draw heavily on WHO for this analysis.

1. Efforts to control communicable diseases are a continuing commitment of governments and non-governmental agencies, and if there is a future decrease in morbidity from these diseases, certain types of disabilities will be reduced. On the other hand, greater survival through improved medical care for disabling illnesses may contribute to an increase in certain types of disability.

2. The world food situation is a matter of continuing concern, and present trends show a steady increase in the problem of malnutrition. This will lead to an increase in the number of persons disabled as a result of the immediate and longterm effects of under-nutrition.

3. The changing age composition in the world and extending life expectancy in many countries will certainly contribute to changes in the characteristics of the disability problem.

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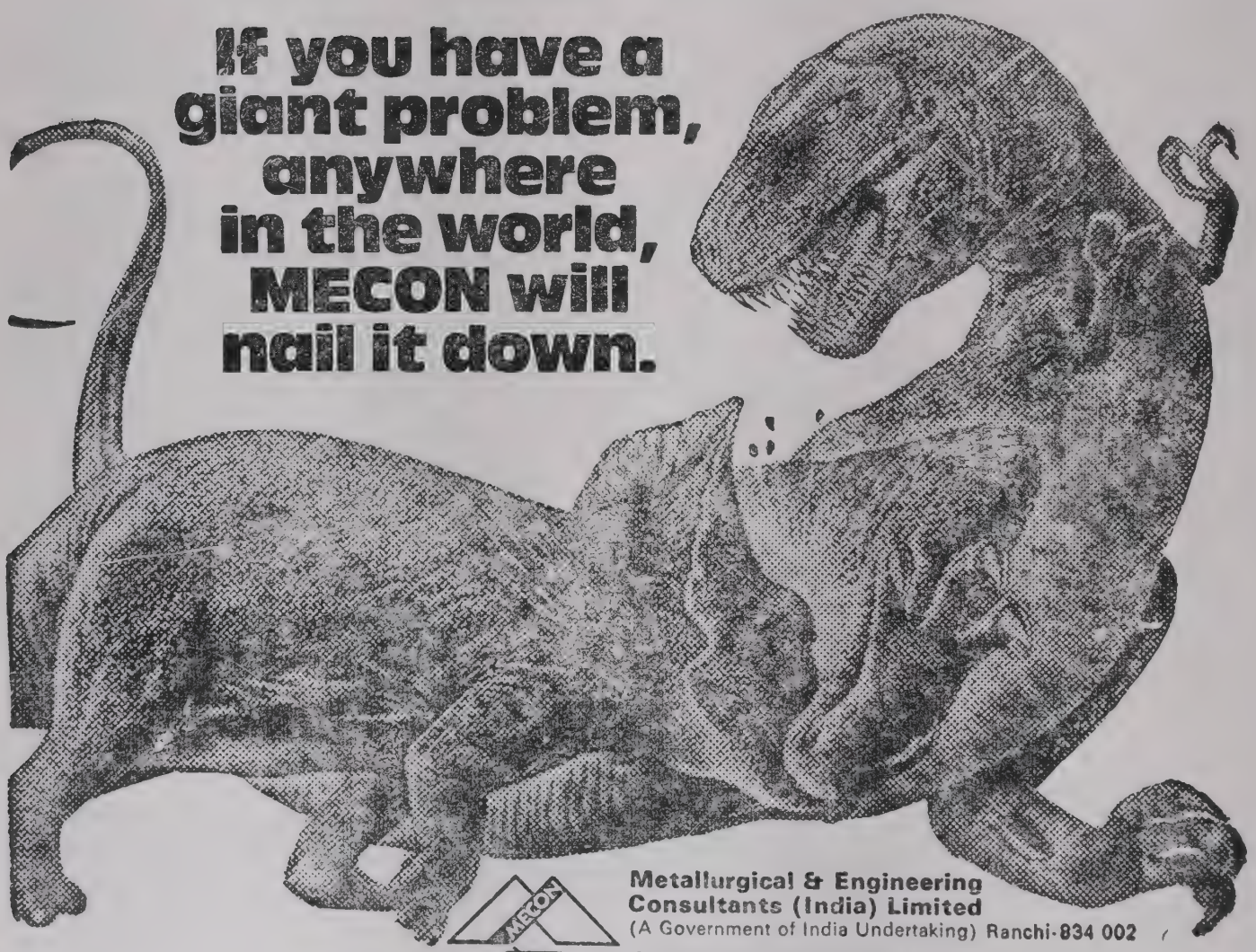

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Table 1.* Causes of disability and estimated number of disabled people in the world

Medical cause		Estimated disabled people (world population 4000 million)	
		Millions	%
Congenital disturbances :			
Mental retardation[1]	...	40	7.7
Somatic hereditary defects	...	40	7.7
Non-genetic disorders	...	20	3.9
Communicable diseases :			
Poliomyelitis	...	1.5	0.3
Trachoma	...	10	1.9
Leprosy	...	3.5	0.7
Onchocerciasis	...	1	0.2
Other communicable diseases	...	40	7.7
Non-communicable somatic disease	...	100	19.3
Functional psychiatric disturbance	...	40	7.7
Chronic alcoholism and drug abuse	...	40	7.7
Trauma/injury :			
Traffic accidents	...	30	5.8
Occupational accidents	...	15	2.9
Home accidents	...	30	5.8
Other	...	3	0.6
Malnutrition	...	100	19.3
Other	...	2	0.4
	TOTAL	516	100.0
Correction for possible double accounting (−25%)	...	129	
	TOTAL	387	

1 Not all of these are congenital cases.

* From "Disability prevention and rehabilitation". Reports on *Technical Matters* Twenty-ninth World Health Assembly. Document A29/INF. DOC/1, WHO Geneva, 28 April, 1976.

4. Increased urbanization and industrialization also contribute to increasing disability problems. The factors here are multiple and complex, but certainly include road and industrial accidents as well as the psychosocial pressures of urbanization.

The problem faced by developing countries is particularly great. This is true not only because the number of people with significant disabilities is undoubtedly larger in these countries compared to the total population, but also because of the limited resources which these countries have at their disposal to respond to the needs of disabled persons. A brief example will serve to illustrate this point. Botswana is a country with relatively low population in southern Africa and it is among the countries referred to by the United Nations as one of the least developed countries. The current population is estimated to be around 700,000. A study was recently made of the needs of disabled people in Botswana for the purposes of planning for an expanded service of rehabilitation in the country.* This study began with the basic assumption that, within any population, 10% of the people have medical, social and economic problems related to disability. At least one in ten of these, or some 7000 people, would be in immediate need and can benefit from rehabilitation services. At that time, the country had very liltle organized rehabilitation actually functioning. Institutions run by non-governmental organizations had a combined capacity of about 60 persons and could admit about 20 new people with disabilities per year. There was a clear need to further extend services to reach more of the population in need.

The first option open to the planners would be to provide more specialized rehabilitation institutions of the type already estabilised, institutions which would be considered the conventional response. For this option, capital costs would obviously be very high, and the need for professionals to run these services would demand between 700 and 1000 highly trained people (expatriates would undoubtedly be required to fulfil this need for a long time until nationals could be trained). However, in addition to these facts, it was conservatively estimated that the running costs for this conventional response, if the needs of these 7000 people would be met, would amount to twice the total annual budget for the Ministry of Health. Obviously, some new and creative thinking was needed for Botswana as it is needed for other countries as well. One option suggested by this study is that of community—based rehabilitation; this required no institutions except for a few referral stations which would be developed later in response to community needs. The total professional staff required is less than 20, and the annual running costs would be equivalent to about 2% of the national health budget. In this approach, basic rehabilitation would be carried out in the community itself and usually with the home of the disabled person. This would consist of simple therapy, the provision of simple technical aids made locally, teaching in order to restore the capacity to participate in the

*Helander, E. : Personal communication.

activities of daily living, the provision of work situations appropriate to the specific disability and other social measures. This effort has taken into consideration the fact that the effectiveness of conventional institutions is seriously questioned now because they so often run counter to the objective of keeping disabled people within the mainstream of life. The rehabilitation itself is entrusted to primary health care workers and other community members including family members. Government and non-governmental organizations are all drawn into the total effort. This is the kind of creative thinking and planning which will be demanded of all of us during this year and for the years to come.

Perhaps one other illustration will serve to reinforce this point. Southern Asia is known to carry a heavy burden of eye problems and has a high incidence of blindness. It is estimated that of the 15 million blind people in the world, 5.8 million are in India alone. About 30% of these blind people are believed to lose their eyesight from preventable childhood illnesses. Another very large percentage are from other diseases which are either preventable or can be treated at an early enough stage to prevent the loss of eyesight. In the South India State of Kerala, a project has been under way for some 21/2 years under the joint auspices of the Christoffel-Blindenmission of the Federal Republic of Germany and the MGDM Hospital in Kangazha. This "Preservation of Eyesight Project"* has concentrated on the prevention of blindness through measures taken at the village level, using specifically trained village health workers. The training programme utilized volunteers selected by their own communities, and the training lasted eight weeks. In addition to a supervisory level of worker, a referral system was utilized for support from the base hospital. The activities at the village concentrated on the prevention of vitamin A deficiency, nutritional programmes to prevent protein-calorie malnutrition, the prevention of childhood diseases through immunization, the early detection and treatment of eye diseases, screening for the detection of cataract, glaucoma, diabetes and hypertension, a school programme to screen the vision and treat regracted errors in the children, and the rehabilitation of blind people through vocational training. The results have shown a remarkable reduction in many of the most serious eye-threatening problems and a new awareness of both the value of prevention and the possibilities for severely disabled people to re-enter the mainstream of life through training.

A similar project in the neighbouring Indian State of Tamil Nadu* also makes use of the village-level field worker for the purposes of screening for eye problems, training blind people in the activities of daily living, vocational training and follow-up. An extensive experience has been developed in this project in the training of these disabled people in many specific activities to enable them to become fully independent in and around their own villages.

The World Health Organization itself is undertaking a programme of prevention in the Himalayan state of Nepal where, among its 12 million people, 1/4 of a million are known to be blind. Ninety per cent of the blindness identified in a survey carried out two years ago was found to be either preventable or curable. The aim of this programme is to focus on the preventive efforts that can be carried out within the communities to eliminate the huge burden of avoidable blindness in that country. The bulk of the work will be carried out by village health workers, and a health education campaign has been launched for the population in five priority areas. Drugs and basic instruments will be made available to all district and health post centres, and an ophthalmic eye unit will begin to function in the very near future.

*Joseph, M.V. : "Preservation of Eyesight Project : and Experiment in Prevention of Blindness at Community Level" (un-published manuscript dated August 1980).

*Jaekle, R. : "Rehabilitation of Blind Persons in Rural India", Journal of Visual Impairment and Blindness, June 1977, pp. 241-347.

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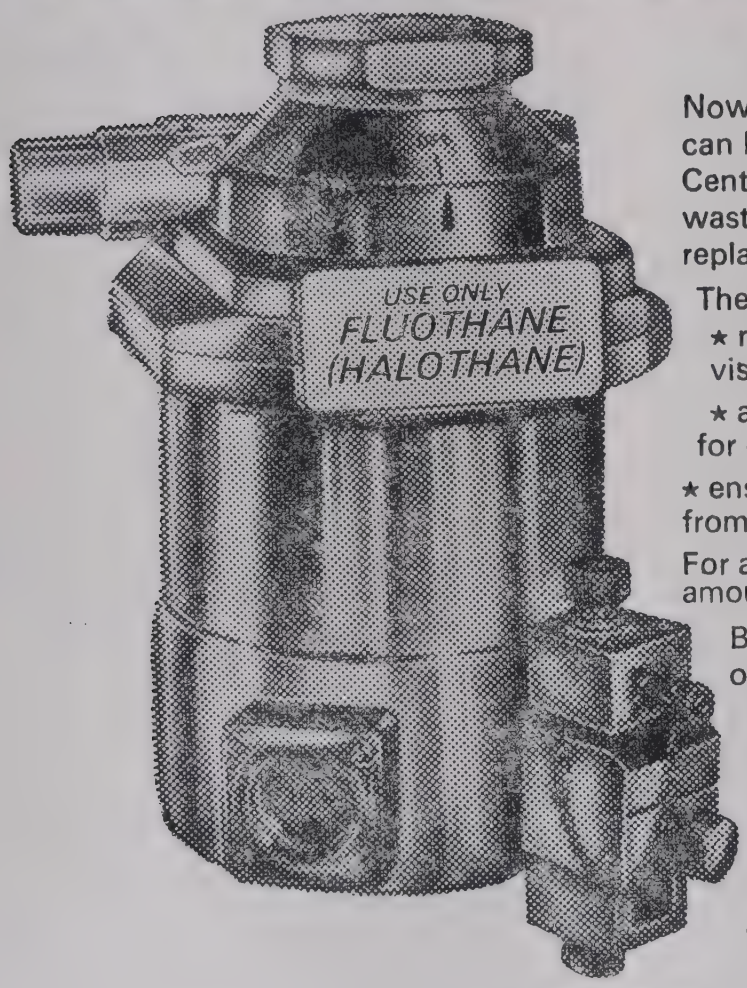

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Socio-Economic Programmes for the Disabled Persons

SEBASTIAN THERUVAKUNNEL

A vast majority of the disabled persons in India are dependents and lead a sub human life. Serious and large scale measures are to be taken up immediately to rehabilitate them socially and economically

Introduction

THE problem of disabled persons existed down through centuries, but its impact was never felt before as it is today. Till about a century back charity was the only solution to this problem. But those who lived on charity got only sympathy and not acceptance and dignity in the society. Thanks to the new philosophy and experiments, charity is no longer considered as the solution to this problem. Today, effort is going on throughout the world for the economic and social rehabilitation of the disabled persons. The growing problem of economic instability and the unemployment situation has created several socio-economic problems in all societies and this has worsened the condition of the disabled persons. This in turn increases the stress of every man. Alarmed by this grave situation, the United Nations declared 1981 as the "*International Year of the Disabled Persons*"—(*IYDP*).

Definitions

Various programmes have been suggested and planned already for the welfare of the disabled persons, and at least a few have got underway. Even today the problems of the disabled persons are not properly understood, even by many who implement programmes for the disabled. '*Disabled*' and '*handicapped*' are two closely related terms. A handicapped person may be defined as one who is not able to lead a normal life either due to personal deformity or due to malfunctioning of the society. This includes blind, deaf, orthopaedically handicapped, mentally deficient and retarded, laprosy patients and socially and economically backward people. The last two groups—socially and economically backward—may be excluded from the list of disabled persons, though in the strict sense they too are disabled. An indepth analysis of the causes of these handicaps will show a close relationship among these handicaps. This calls for an integrated rather than segmental approach, based on a dynamic understanding of this dynamic problem to mitigate the ever increasing problem of handicapped persons.

Programmes

I would like to suggest the following programmes for the socio-economic rehabilitation of the disabled persons.

1. Socio-economic Survey

Any plan to be successful has to be based on concrete data. Unfortunately, all programmes for the disabled persons in India are planned without adequate facts and figures. So far no survey has been conducted at the national level to find out the exact number and socio-economic condition of various types of handicapped persons. A comprehensive survey of the handicapped persons will help better planning and the best utilisation of available resources.

2. Social Rehabilitation

The attitude of the society towards disabled persons has to be changed. Even now many people attribute the disablement to the bad deeds of the person himself in his previous birth, or of his close relatives. As a result disabled persons are not easily accepted in the society. Social isolation is a major problem they face in the society, and more often than not in the family as well. People should be made aware of the fact that most of the disabled persons are the products of the society. Except the heriditary factors all other factors of disablement can be attributed to the society. Hence, society should accept its own products and should look to their needs, while recognising their dignity and rights as human beings.

3. Social Awareness

The best way to reduce, if not solve, the problem of disabled persons is to prevent the incidence of disablement. This can be achieved only by making the public aware of the magnitude and seriousness of the problem, the various causes of disablement and the preventive measures. Though treatment and training facilities for the disabled persons are available in various parts of the country, only a few are aware of them. People should be made aware of the existing facilities, and there should exist a network to help the people to avail these facilities. Appointment of trained social workers in hospital and other welfare institutes will certainly help in the creation of awareness among the people as well as social rehabilitation of the disabled.

4. Communication

Communication is an essential part of any welfare programme. There should be effective communication between the policy makers, planners, the people who administer welfare programmes, the intended beneficiaries, and the common public.

5. Education

As far as possible, arrangements should be made to educate the disabled children in ordinary schools. This will help the formation of a positive attitude among normal children towards disabled children. The disabled children will be able to enjoy life better in an ordinary school, than in a special school for them.

6. Vocational/Technical Training

Time was, when disabled persons were considered as complete parasites. But time has proved that they can be as independent as anybody else, provided they are given training in the work that suits their deformity. The fields in which disabled people are largely employed are typing, stenography, electronics, telephone operations, tailoring, press works like proof reading, composing, binding etc. and paper bag making. Depending on the physical deformity and intelligent quotient they can be trained in the above stated fields.

At present, training facilities are meagre and it may not even cover one per cent of the disabled persons. Besides, practically all such training centres are concentrated in urban areas while nearly 80 per cent of the population live in rural areas. Therefore, more training centres should be opened in rural areas.

7. Marriage Bureau

Like all other individuals, disabled persons too have the desire to establish family. But often they cannot find suitable partner for them. Very few people come forward to marry a disabled person. Establishment of a special marriage bureau will certainly help many disabled persons to find life partners.

Summary

The impact of the increasing number of disabled persons and the miserable condition in which they live today, has been widely felt by people all over the world, especially in developing countries. In traditional Indian society disabled persons were fully dependent on charity. But time has proved that charity makes people more dependent. Modern medical and technological developments have helped many disabled persons to be independent. But a vast majority of the disabled persons in India are still dependents and lead a sub-human life. Serious and large scale measures are to be taken up immediately to rehabilitate them socially and economically. □

THE CHURCH AND THE DISABLED

(Statement of Catholic Bishops of Ontario)

THE Church, inspired by Christ's example, has had a long history of involvement with disabled or handicapped persons. In fidelity to that inspiration the Church continues to be concerned with the role of handicapped persons in the community today.

By handicap is usually meant a condition which impedes full participation in normal daily activities, whether these be physical, mental or emotional.

Significant Numbers

There are many people in the community who suffer some form of handicap. One report conservatively estimates that one child in eight has an emotional or learning disorder.

We must, therefore, be aware of the significant number of Church members with mental, physical or emotional handicaps and the burdens they imply.

Must we not ask ourselves howwell we relate to such people, how sensitive we are to them and how appreciative of them as fellow members of the human family and of the kingdom of God, and how effectively we respond to them and learn from them?

As a Church we have some special insight into the true significance of handicapped persons in society by reflecting on the revelation of God. God, the heavenly Father and Creator of us all, has spoken to us about handicapped persons and their role in society.

The Message of Revelation

We are all—man and woman together, humankind, created in the image of God (Gen. 1 : 27).

We thus represent God in the midst of His earthly creation (Ps. 8:6—8). The people of Israel rejoiced at this and marveled at human wholeness, health and beauty and received these as God's blessings (Ps. 144:12, 15).

From the faith that our wholeness and ability are God's blessing, it was easy enough to slip into the wrong idea that our brokenness and disability were a sign of God's curse (cf. Gen. 3:10, 4:8, 4:23—24). They were rather the effects of sin's entrance into the harmonious world created by Yahweh.

It was in this broken history that God began to reveal Himself as redeemer, healer and restorer.

It gradually became clearer that pride, arrogance and smug self-sufficiecny were the things that separate people from the God of the Covenant—not weakness and disability. Indeed these invite the compassionate God more surely into our lives.

And so, in the psalms and the prophets, we meet the *anawim*-the poor ones, the oppressed who wait in hope for the merciful interventions of the God of Israel, "who is always on the side of the oppressed" (Ps. 103:6).

The Parable of Job

The Book of Job teaches us something about disability. Job, an upright and successful man at peace with his conscience, is stricken with poverty, breavement and physical deterioration. His friends tell him that it must be his own fault, because God is just and never punishes a sinner except in proportion to his sin.

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Job, however, refusing to accept the narrow theology of his friends, trusts in God, and God eventually restores Job to happiness and peace. Significantly, God does not "explain" to Job why it all happened. To be sure, the problem of evil is not to be solved by words, even holy words. It will be understood and met only in the solidarity of suffering love and in the hope embodies in Jesus Christ, the Suffering Servant.

For the prophets, one of the signs of God's kingdom is that the handicapped person will be cured : "Then the eyes of the blind shall be opened,/the ears of the deaf unsealed,/then the lame shall leap like a deer/and the tongues of the dumb sing for joy" (Is. 35:5—6).

Isaiah, as other later writers, was also aware of a deeper significance of handicap: "Listen you deaf ! Look and see you blind! Who so blind as my servant, so deaf as the messenger I send?...You have seen many things but not observed them, your ears are open but you do not hear" (Is. 42:18—20).

Jesus and the Gospel

At last, after all this delicate preparation, Jesus was born and gave new direction to our history. In Jesus, God came to identify Himself with the brokenness of us all—in order to heal us utterly. So Jesus could even identify the kingdom of God with our weakness and longing.

Intrinsic to His redeeming ministry was Jesus' concern for handicapped, despised, sick and oppressed people: "The Spirit of the Lord is upon me, because He has anointed me to preach good news to the poor. He has sent me to proclaim release to the captives and recovering of sight to the blind, to set at liberty those who are oppressed, to proclaim the acceptable year of the Lord" (Lk. 4.18—19).

It was not only that suffering crowds of people wanted Him to heal and made Him famous as a healer (Mt. 4:23—25). He Himself saw the rehabilitation and cure of disabled people as crucial to His ministry : "Go back and tell John what you hear and see, the blind see again, the lame walk, lepers all cleansed, the deaf hear and the dead are raised to life, and the Good News is proclaimed to the poor. And happy is the man who does not lose faith in me" (Mt. 11:3—5).

There is more. For Jesus, physical healing was a sign of His mission, indeed a sign that the kingdom of God was at hand (cf. Mk. 1:15). As a sign, it pointed to an even greater transformation. In the midst of His struggle to open His disciples' minds to the mystery of His coming death, Jesus groaned and prayed as He enabled the deaf man to hear and to be open to Him. In like fashion, He restored sight to the blind beggar as He journeyed to Jerusalem (Lk. 18:31—43). He opened the eyes of the manborn blind as He wrestled to penetrate the religious pride of the upright Pharisees with God's new word. His words here are significant: "It was not that this man sinned, or his parents, but that the works of God might be made manifest in him" (Jn. 9:3).

In all these struggling encounters, Jesus was engaging the deep, hidden powers of sin and of the adversary that dominate us through hardness and pride. It was in their disability that people were able to recognize their need for Jesus, and to receive Him in His power to transform. Jesus was drawn to the weakest among us and those who recognized their weakness were drawn to Him.

Signs

So there are two signs at work, each charged with power to reveal what Jesus is teaching us. The first is the sign of healing—bodily healing and social rehabilitation—as a pledge of God's intention to restore us altogether to wholeness and communion. But while we wait for Christ's glorious coming to complete that work (already in progress), there is another sign.

The second sign at work is the symbolic function of these among us who are disabled. They are a sign not only because their disability is indicative of how we all are before God—powerless and in need of the tronsforming power of God—but also because their disability identifies them in a special way with the saving, crucified Lord.

As St. Paul says, "Now I rejoice in my sufferings for your sake, and in my flesh I complete what is lacking in Christ's afflictions for the sake of His body, that is, the church" (Col. 1:24).

In dying on the cross for us, Jesus entered without reservation into the "unfairness" we suffer and inflict on each other; into our mortal weakness and helplessness, into utter disability. In doing that with such obedience and love, Jesus saved us from all the power of evil. The Father witnessed to that transformation by raising Jesus from the dead. His humanity now is glorious; fully the image of God, fully alive with the power of the Spirit, the promise of the same fullness of life that will be ours at the Second Coming.

Now Christians are able to see in the faithful life of a handicapped person a concrete participation in the process by which Christ saved all of us. It is a visible illustration of how for all of us, God is willing to be

most present in our weakness and brokenness to redeem the world.

At a very deep point in the soul, disability is an invitation to contemplation, to surrender to the gentle power of God which transforms our weakness.

Saint Paul

Saint Paul spoke of that vision when he prayed for healing from a burdensome ailment of his own, and received instead this promise from God: "My grace is enough for you; my power is at its best in weakness." Saint Paul went on: "I will all the more gladly boast of my weaknesses, that the power of Christ may rest upon me. For the sake of Christ, then, I am content with weaknesses, insults, hardships, persecutions and calamities; for when I am weak, then I am strong" (2:9—10).

Through his own disability, Paul readily understood how difficult disabilities could be. But he saw, too. that disabled people, out of love and service, could exercise a genuine ministry in the church, indeed a salvific one, by uniting themselves with the Suffering Servant.

Church Response

The church at the time of the Second Vatican Council took up this theme of disablement and suffering and spoke forcefully to all who would care to listen: Christ was sent by the Futher "to bring good news to the poor, to heal the contrite of heart" (Lk. 4:18). "to seek and to save what was lost" (Lk.10:10).

Similarly, the church encompasses with love all those who are afflicted with human weekness. Indeed, she recognizes in the poor and suffering the likenness of her poor and suffering Founder. She does all she can to relieve their need and in them she strives to serve Christ...

The church, "like a pilgrim in a foreign land, presses forward amid the persecutions of the world and the consolations of God," announcing the cross and death of the Lord until He comes (cf. 1 Cor. 11:26). By the power of the risen Lord, she is given strength to overcome patiently and lovingly the afflictions and hardships which assail her from within and without, and to show forth in the world the mystery of the Lord in a faithful though shadowed way, until at the last it will be revealed in total splendour (Dogmatic Constitution of the Church, n.8).

Pope Paul VI, later in a message to handicapped pilgrims ("Faith and Light" L' Osservatore Romano, Nov. 6, 1975, p. 10), became more explicit still and invited us to be one with our handicapped brethren and bring them into full participation in the church.

In spite of well-meaning declarations of principles and of much good work that is being done, there is a great risk that our society continues to marginalize the weak; to marginalize those whose insertions into society requires greater imagination, and a more selfless love and hope. But let us be in no doubt that such insertion is the most authentic sign of a truly human family and of a truly civilized society. Even more is it the sign of a truly Christian church. These handicapped people, let us not forget, have their hands outstretched to us but they also have a message for us.

As a church, of the healthy and disabled, we must live our full potential as human beings, while accepting gratefully from one another the contributions we can make both to the church and to society.

Jean Vanles (founder of the 1' Arche communities that are composed of some persons who are physically handicapped and some who are not) has drawn our attention to one specific and blessed role of mentally handicapped persons. He has written that mentally retarded persons restore the balance of the virtues of sensitivity and love. They force society, if it heeds their appeal, to soften the hardness of its technology and administration. Through their weakness they constitute a challenge (cf. Eruption to Hope p. 44).

Vanier also observed (cf. "Living Our Faith with the Retarded Person," National Apostolate for Mentally retarded Persons, Feb. 9, 1972) that once handicapped persons meet Christ they are no longer handicapped. We know what he means.

There is a need to recognize the conflicting forces within the handicapped person. God did not create any one of us as a solitary being, yet disabled people are dependent to a greater or lesser degree on others for social exchange, communication and for transportation. Through their calll of Baptism and Confirmation, they desire to contribute to, as well as receive from, the Christian community. We must assist them to discover both what they are called to do in the church and how the community in its turn can serve them. How effective too it would be to encourage so many handicapped persons to express themselves both in word and deed.

The church must make a response that is fully human and faithful to her commission. She must look at the gifts of all persons and ask the questions: How can the particular diocese or parish call forth these talents to the fullest? What changes are necessary to make this possible for all members ? What resources

are available that will "enable" the gifts of handicapped persons and allow them to become more acitvely involved in the ministry of a given parish? "By his innermost nature man is a social being, and if he does not enter into relations with others he can neither live nor develop his gifts" (Vatican II, Pastoral Constitution on the Church in the Modern World, n. 12). To enter into relations requires accessibility in the broadest sense. How accessible are our churches and our church facilities to our disabled members?

Remove Obstacles

It goes without saying that the first obstacles to be removed are our own prejudices and lack of openness to disabled people. How important it becomes for us to welcome them with hand and heart and to make them feel thoroughly at home. We should avoid, too, anything that suggests paternalism or condescension. The mere removal of physical or architectural barriers can never replace the open minds and hearts of fellow parishioners.

As surely as we recognize the uniqueness of individuals, we must also recognize the need for basic equality between all members of our church. Social or cultural discrimination in basic personal rights on the grounds of handicapping conditions must be considerd incompatible with God's design and the mission of the church.

In order to make progress, the people of God must remain constantly open to the removal of any communication barriers, as well as to the need of changing personal attitudes and of ongoing programmes of education.

Eeven if it takes some time to arrive at the desired goal of full and active participation in the church for all its members, their equal dignity as persons compels us to work to this end-this oneness with the Father.

Role of Society

There may have been in the past less awareness on the part of society in general of the needs and care of handicapped persons among us. Indeed, the church relied heavily upon the devoted services of religious communities to care for our handicapped brethren. All of us owe a deep debt of gratitude to such men and women.

It can be said that modern society is more aware of its handicapped members and more sensitive t olegislation, social changes and support as they affect handicapped individuals. Associations for the handicapped are better organised and more active, 1' Arche centres have become much more evident across Ontareio, Canada, schools have become much more aware of the special needs of handicapped students and governments are faced with human rights issues and need for new legislation.

The question this needs asking is that one: Are we as Christians as aware, as understanding and as supportive as we should be? As individuals, do we really care and do we ally ourselves with those devoted people who struggle so generously to meet the needs of handicapped persons at every level of society?

Community-consciousness seems to be a key issue. Are we caring and loving enough to share ourselves with the handicapped people that cross our paths? As parishes, as individuals, do we address ourselves honestly and persistently to handicapped people who form with us the great community of the people of God ? Are we prepared to confront government to ensure just policies? As a church, are we interested in leadership of this kind?

If 1981 is going to be a meaningful year for those who are disabled then we must act as believers and consider their situation and demonstrate fresh interest and tangible support, and we must not wait for others to initiate action. The mere question of removing physical obstacles for handicapped persons in a parish church or center is in itself a direct challege to a pastoral council, a pastor and the parishioners as a group.

Practical Recommendations

We would like to be as practical as possible in regard to community openness to and acceptance of all who are handicapped. Therefore, we offer the following concerns and recommendations as they have come to our attention from handicapped people themselves and from those who exercise a special ministry toward them.

Diocese: We must initiate those physical improvements and liturgical adaptations that will allow handicapped people to participate more fully and meaningfully in the community worship; we need to introduce into the education of seminarians special training in programmes and methodologies; there is a special need for the formation of diocesan committees to meet the requirements of handicapped persons, committees with representation from the handicapped people themselves; there is a pressing need for a counseling service for the parents and families with handicapped members; also for resource centers to dispense basic information indicate the practical help available at various levels; nor

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must we neglect the role of the handicapped person in the area of new ministries within the church; in general, there is such a need to create for the handicapped person the sense of acceptance and belonging.

Parish : Concerted efforts on the part of the pastor and parish council to search out and welcome the handicapped people and to ensure their full participation in liturgies, sacraments, prayer groups, retreats and other parish activities of a social nature; and overriding concern for the spiritual development and growth of handicapped persons who will of necessity need more rather than less special attention; full acceptance of the handicapped individual and his or her talents.

Special parish needs: visual helps such as slides, transparencies, special lighting, sign language interpretations for the deaf; books in braille for the blind and printed homilies for the deaf; special preparation for the reception of the sacraments; the important question for so many of transportation to and from the church, ramps and railings, parking space near the church doors, adaptation to some pews, doors and washrooms.

Government and Society: We must ensure the basic human rights of handicapped persons as a matter of justice and collaborate with all those who are working to this end; the right to life itself and all that implies; educational opportunities for all and, specifically, for Catholics, within the Catholic school system; removal of all discrimination in regard to housing and employment, cultural and recreational opportunities; as much as possible, full integration into the human community any avoidance of unnecessary long-term institutionalization; assistance to families with handicapped members in procuring suitable health and social services.

Conclusion

It is, we believe, that by conforming our attitudes to what we have said and by doing something concrete that we shall show our Christian and social solidarity with our handicapped brethren. While it is true that we do not have to do everything at once, still we should begin—"the love of Christ overwhelms us" (2 Cor. 5:14).

What we should try to understand more deeply and live out in our day-to-day existence is the nature of the church as the Mystical Body of Christ. All, no matter what their state or condition in life may be, are precious members of Christ, united to one another in Christ. We have only to recall the Lord's memorable assertion: Insofar as you did this to one of the least of these brothers of mine, you did it to me" (Mt.25: 40).

The bonds of such a strong and acceptable unity within the Christian community will be a sign of the unity and diversity that mark the Blessed Trinity.

Paul's inspired words surely give us the motivation we need: 'All baptized in Christ, you have all clothed yourself in Christ, and there are no more distinctions between Jew and Greek, slave and free, male and female, but all of you are one in Christ Jesus" (Gal. 3:27—28). And as we read in the Acts of the Apostles about the early Christian community "now those who believed were of one heart and soul" (Acts 4:32).

The Christ and His salvific mission embraces one and all, and in a special way those handicapped people who are the "anawim" of the Gospel.

Courtesy : "Catholic Faith"

DOCTORS OFFERD LOAN TO SET UP RURAL CLINICS

Medical practitioners wanting to open a dispensary, clinic or nursing home have been offered loans up to Rs. 1 lakh by 26 major banks.

The objective is to encourage more doctors to set up practice in villages or semi-urban areas. Practitioners of all systems of medicine will be eligible for loans.

The money will be repayable between a period three years to eight and half years. It will carry interest ranging from 11 to 18.35 per cent.

While the maximum loan of Rs. 1 lakh is being offered by Bank of Maharashtra and Union Bank of India to medical and dental graduates in rural and semi-urban areas, Allahabad Bank has announced a scheme for advancing loans up to Rs. 50,000.

Assistance of up to Rs. 8,000 has been offered by Indian Overseas Bank to young medicos who want to start practice in a rural or semi-urban area.

Canara Bank offers upto Rs. 5,000 for doctors who are willing to go to villages. Dena Bank has come up with a scheme to help dental surgeons with loans up to Rs. 25,000 for setting up clinics in rural and semi-urban areas.

Doctors returning from abroad have also been offered assistance by Allahabad Bank.

Most banks have provided for assisting doctors to buy equipments or vehicles.

Times of India
Sept. 23

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CHRISTIAN TO THE HANDICAPPED

by

FR. GEORGE LOBO, S. J. PAPAL ATHANEUM, PUNE

It is well known that 10% of the World's population or nearly 500 million human beings are markedly disabled, whether in body or mind. With increasing accidents, environmental pollution and malnutrition among the poor, the number is on the increase. The disabled suffer even more from isolation and frustration than from the physical or mental impairment. Traditional society tried to cope with this reality by segregating the sufferers and even declaring them ritually unclean. Some went to the opposite extreme and attributed magical powers as *shamans* or *soothsayers* to them. Anyway, they were looked upon as freaks.

Wrong Attitudes Today

(1) *Shying away from the handicapped out of horror or fear.* This happens because of the lack of the spirit of brotherhood. The reaction also arises due to the idealization of the figure of the young, athletic, fully productive human. This leads people to disparage the handicapped as second class human beings. If the value of the human person is measured by efficiency, then the disabled will be looked upon as a shame or liability to the family or society. That is why, many families try to hide the presence of a disabled person in the home. As grave disability is the manifestation of the mystery of evil, without religious faith, man would not be able to cope with it and try to hide it or run away from it.

(2) *Commiseration of the disabled* as 'unfortunate' pitiable human beings immediately creates a gulf. It induces a sense of false superiority or fear in the able bodied, and reinforces feelings of inferiority in the disabled. Pity evaporates quickly or manifests itself in paternalistic aid that results in a relationship of dependency. Pity can be as hurting as rejection since the receiver is made to feel that he has to expect everything from us. Some evade the issue by giving a pittance as alms. Then they don't have to face the terrible reality. The objects of pity themselves dare not enter into contact with others although they yearn for it.

(3) *Guilt.* Parents who bear a defective child often tend to attribute it some fault. Thus the mother may think it was due to her behaviour towards her mother-in-law during pregnancy. This may lead to over-compensation by showing undue solicitude towards the child even while there is basic rejection at the unconscious level. The person himself may think it is due to one's '*fate* or '*Karma*', perhaps arising from a fault of the previous life.

(4) *Glorification of suffering.* One should not too glibly speak of grave deformities as a 'challenge' or as 'part of life'. Suffering is not an end in itself. It is an evil. It is not enough to console the handicapped merely with the hope of future happiness.

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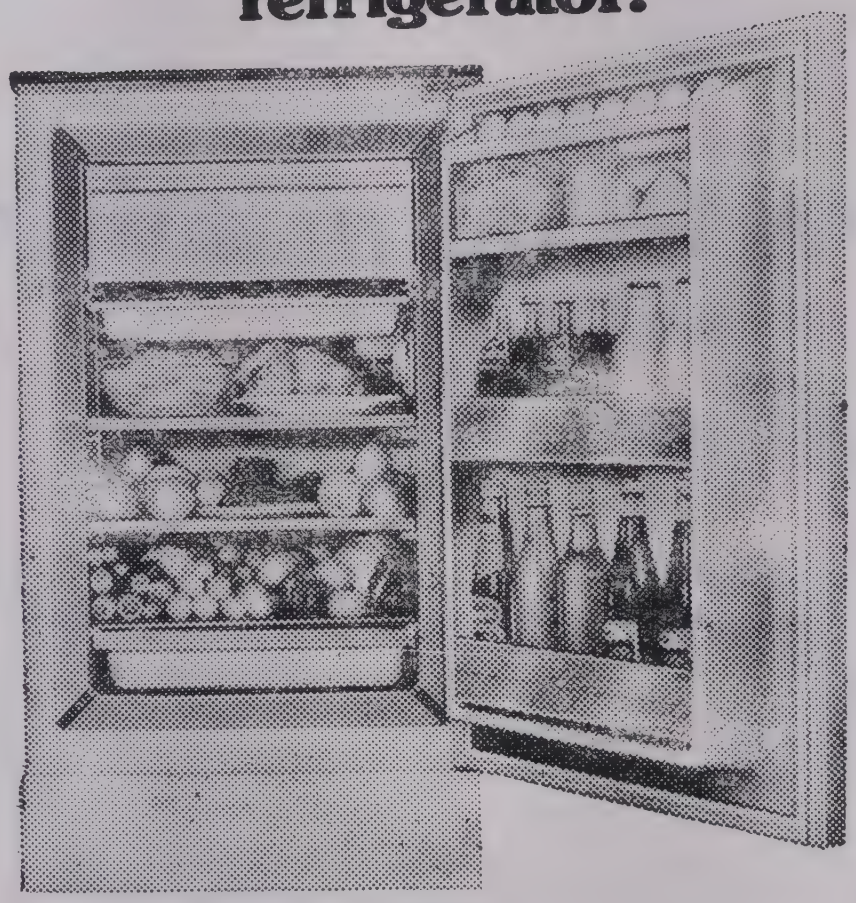

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Like Jesus, the Church must attack the evil, use all its resources to relieve the distress.

Example of Jesus

Jesus the 'whole man' and the one who came to make man whole, first of all identified himself with the handicapped and the brokenness in the world. He fulfilled the figure of the Suffering Servant of Yahweh (Is 53 : 1—5) and came as the brother of the poor and the suffering. He was particularly inclined towards those who were excluded from the cult—the crippled, the maimed, the blind and the lepers. Not only did he free many from their infirmities, but he himself accepted suffering and death for saving and 'wholing' the world (Mt 8 : 17; Is 53 : 4).

Jesus showed that the Kingdom of God had come for all, the Kingdom which he himself proclaimed by mediating the healing power of God. "He has sent me to proclaim the good news to the captives and recovery of sight to the blind, to set at liberty those who are oppressed." (Lk 4 : 18; Is 61 : 19). He declared : "I came that they may have life, and have it abundantly." (Jn 10 : 10).

The crowds recognized the mission of Jesus to heal, to restore and integrate the whole man within himself and in society by exclaiming : "*He has done all things well, he even makes the deaf hear and the dumb speak.*" (Mk 7 : 37). The salvation which Jesus brought does not stop at the soul, but penetrates the bodily level of man in the totality that is the image of God. It is the restoring of the personal identity that belongs to God's original plan that has been broken by sin, although particular deformities cannot be attributed to the fault of anyone in particular.

Role of the Church

As the Church is the *sacrament* of the unity of mankind, she must manifest total openness to all her members. Yet able bodied members tend by their attitudes of superiority and their emphasis on activism to marginalise or exclude those with mental or physical disabilities, not to accept them as integral members or not to recognise their specific contribution to the welfare of the Church and society.

The Church cannot exemplify the restored humanity or bear witness to the interdependence of humankind if she continues to acquiesce in the social isolation of disabled persons or deny them full participation in her own life. The unity of the People of God is handicapped where they are treated as mere objects of condescending charity; it is broken where they are left out. Hence the full acceptance of persons with handicaps within the life, witness and service of the Church is a basic requirement for her own wholeness.

Even today the Risen Lord identifies himself with the handicapped. He encounters the community specially in them. The genuineness of the community's Christian life is to be guaged from its response to those who are outcast, suffer or are dispised in any way.

It is the permanent task of the Church to gather and integrate all the members of Christ's Body, disabled or not. There is need for evolving forms of worships in which the disabled can express themselves. The mentally retarded have the right to a suitable catechetical and religious formation. The blind deaf and mute have the right to special facilities for the reception of the sacraments.

The disabled have a special role in announcing God's word of salvation. Their very presence purifies our faith by giving a face to our deepest questionings regarding the meaning of life, suffering of the innocent, the justice and tenderness of God. There is the story of a man who came to Lourdes to be cured and receive the favour of admission to the teachers' training school. Just then a mongoloid child was brought in. The person only looked at the child and prayed for him. He was himself not cured nor did he become a teacher; but he was transformed.

In a world where what is appreciated is only power, physical beauty and social success, the first communion of a Mongoloid child manifests the 'subersive' power of the Gospel. The work of God in such disabled persons breaks down our categories.

The presence of the disabled in the community reminds the rest that every human being is frail and threatened. It makes it easier to admit that no life is exempt from handicaps of some sort. On the contrary, excluding the disabled would pose the danger of the rest losing the opportunity of partnership and the full riches of human experience. Hence there is need for acceptance of the handicapped within the mainstream of ecclesial and social life. The obstacles in the form of prejudices should be removed.

Support for the Rights of the Handicapped

While the Church must fully integrate her disabled members in her life and mission, she must defend the rights of all the disabled who have been made to the image of God. Whatever the degree of their physical or mental impairment, they retain their basic right to be treated as human persons and to participate in human affairs to the maximum limit of their capacity. The Christian should work together with all people of good will to ensure the rights of the disabled that have been proclaimed by the *United Nations* on 9th December 1975. Here is a summary of these rights:

1 to be helped to develop aptitudes so that they can be integrated to a normal social life ;

2 the rights belong to all without distinction or discrimination founded on race, colour, sex, language, religion, political views, national or social origin, financial status, birth or any other situation;

3 to respect of human dignity and to enjoy a decent life, as normal and developed as possible;

4 to maximum autonomy;

5 to treatment, rehabilitation, education, professional training; to all aid necessary for maximum development of capacities and aptitudes for integration in society;

6 to economic and social security and to a decent level of life; to have a productive and remunerative employment;

7 to live in one's family or other home and to participate in all social, cultural, creative and recreative activities; if institutionalisation is necessary, to the conditions of life most appropriate to a normal life;

8 to protection from all exploitation, regimentation, discrimination or degrading treatment.

Concrete Action

Besides defending the rights of the handicapped, Christians, individually and collectively, are called upon to work for the prevention of disability and for the cure and rehabilitation of handicapped.

1. There is first of all the need for tackling the *causes* of disability like war, environmental pollution, abuse of alcohol and drugs, malnutrition, dangerous traffic and so on. Today it should be clear that helping particular unfortunate persons, however necessary, will not significantly reduce the number of the handicapped unless such factors are seriously attended to. Hence Medical personnel cannot be indifferent to wider social ills that spawn disabilities on a massive scale. The ever new weapons of destruction that are being invented will cause innumberable casualties that could hardly be attended to with the best of good will. Hence all must raise their voices against the use of such weapons as neutron bombs that spare property but attack only human beings !

2. There is need for some institutions where severely handicapped experience help, protection and care. As far as possible they must provide a home atmosphere.

3. Normally, disabled persons should be taken care of in the *family context*. But others should not think that it is only a family affair. Parents, spouses and relatives need help to cope with the heavy stramp which the presence of a disabled person makes on the family. They need relief from nursing and other tasks. It is very helpful if people come forward to arrange joint holidays and outings for a group of disabled. Not only will this strengthen their morale, but the families will experience some relief on such days.

4. There is need for developing *better techniques and competencies* as well as equipment for the cure and rehabilitation of the handicapped. For instance, the prosthesis should be adapted to the life style and work of various people.

5. Much more effort should be made to provide suitable *employment* for the disabled. With proper training and encouragement, it is amazing what they can achieve.

6. In every case, the maximum *autonomy* of the disabled should be fostered. This presupposes a right orientation on the part of all those who are concerned with them. Autonomy should facilitate *participation* in the life of the family, neighbourhood and the wider world.

7. Handicapped people often need special *understanding* from those around them. For instance, the absence of visual imagery in the congenitally blind may make it very difficult for a child to organise his sensory experience in a coherent pattern and hence lead to wild tantrums. This and so many other factors call for Christian understanding without which the condition is likely to be aggravated.

8. There is urgent need for *counselling services*. The family members need help as soon as the defect is recognized. They may tend to deny the situation, or, after a time, experience disappointment, emptiness, helplessness or sense of personal failure. They must be helped to cope with these negative feelings. The handicapped themselves need help in restoring a sense of self worth and self esteem. Extravagant fantasies or unrealistic goals may cause serious disruption of contact with reality and work against real accomplishments. They may also cause hurts in the physically handicapped. They have to be aided in building up a realistic ego ideal and also in countering guilt feelings or a sense of fatalism.

9. The problem *old people* is increasingly becoming more acute. They need people to visit them, care for them, help them with shopping and other errands. Various Christian associations can find here a fertile field for their charity and zeal. Now it is being more and more realized that old people can keep active for a very long time provided they receive encouragement as well as stimulation for their creative abilities.

10. The social dimension of *mental illness* is becoming more and more clear. It is not only the so called mentally ill that are unable to adjust to society, but often society itself is unable to adjust to those with extraordinary temperament or views. Further the tensions and complexities of modern life cause such acute strains that these manifest themselves in pathological symptoms in many people. Hence the problem of mental illness has both a personal and a social dimension.

Conclusion

The Church must above all witness to the dignity of every human person and show that this is more important than productivity or success. The year of the handicapped should be a year of reflection on the hierarchy of human values. The Church must also defend the rights of the handicaps and foster effective programmes of prevention, rehabilitation and mutual aid.

Considering the colossal nature of the problem, Christian action on behalf of the handicapped cannot be isolated. There is need for *cooperation* among the Churches, with the government and other secular voluntary agencies.

"DO'S, DONT'S"

The migration of health personnel, WHO experts say, "like most migrations is basically a symptom of deeper problems. The desire or need to migrate is bound to lessen as these problems are resolved". "Do's and dont's to help manage the migratory flows :

Do produce as many physicians as the country can afford to employ—that is, "sustainable level"—or alternatively, do increase the demand for their services.

Do plan the numbers and the categories of health personnel the country needs.

Do match education and training programmes to national priorities in health.

Do develop management capacity.

Do rely on yourself, for "no country can really rely on another country to solve its problems".

Do create a national network of local institutions to facilitate technical cooperation.

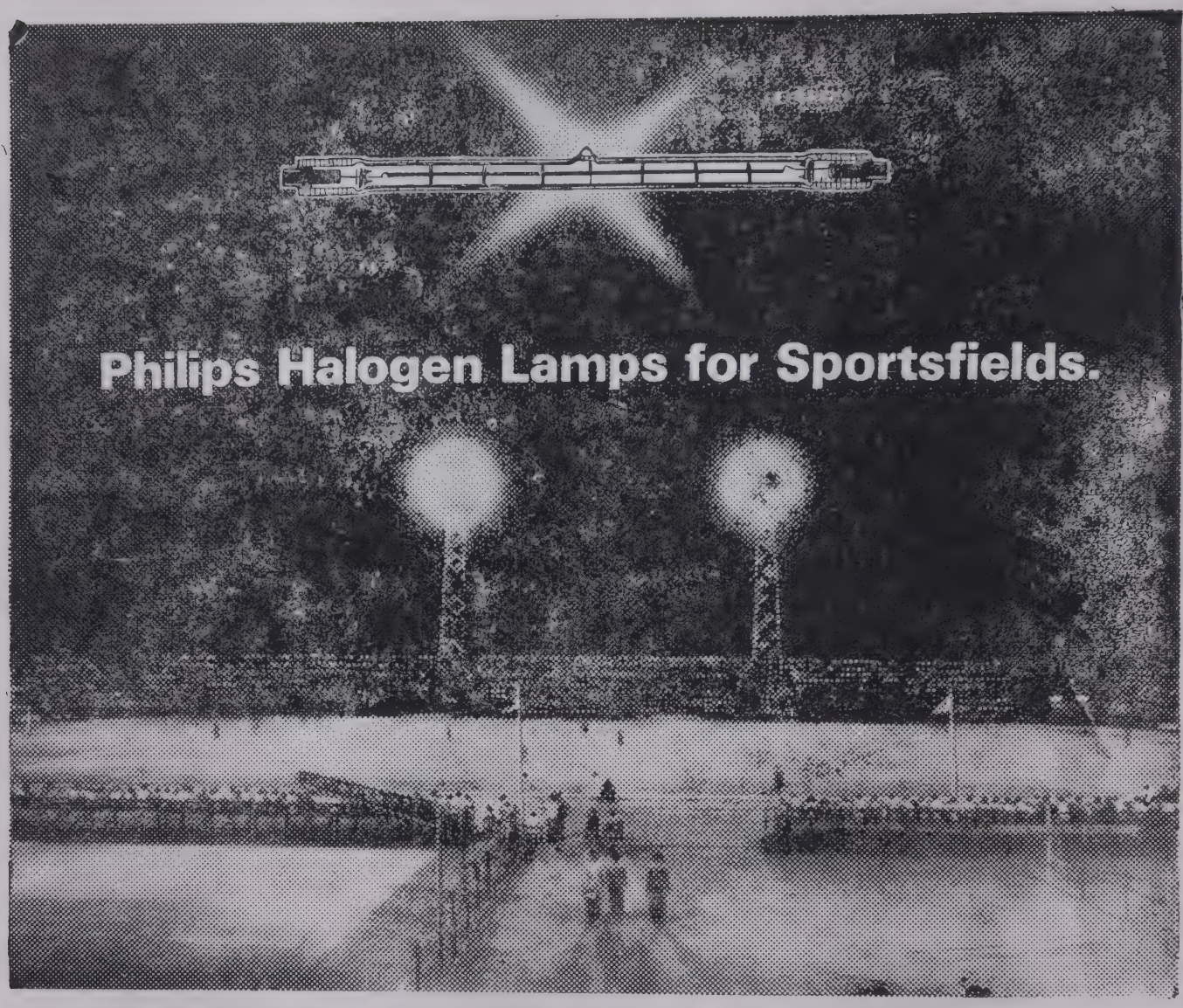
Do not withhold passports "unless you want to create greater discontent and encourage illegal migration".

Do not ban foreign qualifying examinations "since physicians bent on migrating will travel to neighbouring countries to sit such examinations".

Do not try to make salaries competitive with salaries in rich countries, for then the services of physician will be "out of reach of even larger segments of the population".

Do not coerce professional health personnel to work for a specified time in hardship areas unless this applies equally to other professions.

Do not attempt to solve health problems by wanting to have "enough" physicians. "In affluent countries, the notion of enough has no limits", the study says, "while in many poor countries, more than "enough" seems already to have been produced.".



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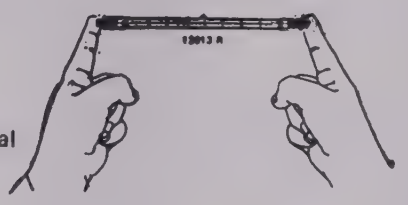

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50 Years in India

Making India's Villages Healthy

By

Rita Mukhopadhyay

IF India lives in her villages, her health cannot live outside them. Dr. K. S. Sanjivi of the Voluntary Health Medical Centre, Madras has been working for the last 30 years to make India's villages healthy. With a vast experience in the medical bureaucracy behind him, Dr. Sanjivi has realised that to be successful we must serve the rural areas.

Dr. Sanjivi now prefers to talk of organisation of health resources rather than delivery of health care. Health care cannot be delivered by one group of people to another. Each society has its own resources. If these resources can be organised properly, health services can be created for everyone. But the question is who is going to pay for rural health care services? This is bothering the health planners. Should all the funds come entirely from the government or should some come also from the people? And if they have to come also from the people, how?

Dr. Sanjivi may have an important answer to this vexing problem. His answer reminds one of the tale of a father telling his sons how a load of woodsticks feels lighter when distributed over many shoulders. Dr. Sanjivi insists that organisation of health resources must be carried out jointly by a public health sector which consists of modern hospitals, medical colleges and research institutes and a private health sector which deals with community health problems. Through health co-operatives both these sectors must complement each other.

Every health co-operative should have local branches, each of which should cover a definite population: half rural and half urban and part rich and part poor. According to Dr. Sanjivi even "*the poorest citizen in a welfare state need not ask for charity: he is entitled to share the available resources or facilities with the richest.*"

In a unique health insurance scheme set up by Dr. Sanjivi, every member family of the health cooperative is charged a minimal fee of half a per cent of its annual income for a family unit of husband, wife and children. All other members of the family, except those dependent totally on the main bread earner (like old parents), are enrolled separately in the scheme. Para-medical workers move regularly from door to door to collect insurance money in advance. In return the members are assured regular health check-ups, immunisation, drugs against common diseases, family planning advice and contraceptives, and sometimes special food supplements in case of malnourished children.

This form of regular and advance payment on the part of community members has a surprising number of benefits. Firstly, the payee is more eager and more concerned about the medical benefits and he gets more sensitive to the needs of his well-being. Secondly, the poorer villagers get greater confidence to make those demands from which they would otherwise shy away. Thirdly, the local rich remain conscious of the investments in which their money is used. And fourthly, these payments bring about greater inter—action—theoretically, at least—between different classes of people and raise their interest in health programmes.

Because of the payment, indifference towards the scheme seldom crops up as it would in any free service. Payments also check apathy among the providers of the service. They feel responsible for regular health-checks and for controlling the costs of the service.

Dr. Sanjivi gives instance of the British National Health Service which suffers from both these drawbacks, indifference and apathy.

Dr. Sanjivi asks : "Should not the well-to-do in our cities contribute 0.5 per cent of their income to a health scheme that not only benefits them, but also helps to keep their poor neighbour healthy?"

Under the scheme, insurance collection amounts to Re. 1 from minimum income groups earning Rs. 200 a month and, a maximum of about Rs. 16.50 from those who earn Rs. 3,000 and more. For families earning less than Rs. 200 a month, medical aid is completely free. The deficit is expected to be covered equally by the state and Central governments through annual donations. But these governments have supplied only one-fourth of the required amount.

The 5000 people covered by one mini health centre thus provide Rs. 6000 in addition to accommodation and furniture. The total annual cost of the centre is, however, Rs. 24,000. The per capita expenditure under Dr. Sanjivi's mini health centre is Rs. 4.8. The government is expected to pay only 75 per cent of this amount. In actual practice, the primary health care centres run by the government serve only 20,000 instead of 100,000 people. Thus, they are spending nearly Rs. 16 per person served, says Dr. Sanijvi.

The insurance scheme lays considerable emphasis on family planning programmes which more and more experts believe should be integrated with the general health care services. Apart form giving advice and contraceptives, Dr. Sanjivi believes that there should be a scheme that provides for fixed amounts to be invested for 20 years on behalf of every parent who undergoes sterilisation. The fewer the number of children the larger is the amount and only persons under the age of 35 should qualify for the incentive. By the time the sterilised person reaches the age of 55, the interest collected on the deposit should be enough to provide a monthly allowance as long as the person is alive. In case of death, the capital could revert back to the health co-operative.

The ultimate question, however, is not one of funds to organise the health services as of educating villagers to take the conscious decision on matters of health. Dr. Sanjivi's health co-operatives have an infrastructure. At the base are the women selected from the permanent residents in the villages, who are given a four weeks' course on treatment of minor ailments, first aid and preventive measures. Every such lay first aider (LFA) is put in charge of a unit of 1000 people and paid a token remuneration of Rs. 50, a month. These LFAs are given continuous in-service training. Under the scheme only women are selected as LFAs because of their specific social role in the villages. The actual choice of the LFA is made by the villagers. Woman stay at home and so are available for consultation all day long. Women also maintain a genuine interest in family affairs. And since most rural health care problems concern women and children, they are more likely to confide in women than men.

The second and third tiers of the health co-operatives consist of two trained multipurpose workers (one man and one woman) for every 5,000 people and a doctor who is available at the mini health centre for three hours a day on three days a week.

The referral hospital, according to Dr. Sanjivi, complements the co-operative health system. Each mini health centre maintains a close liaison with a hospital whether it is public or private, which is closest to it and has appropriate facilities.

Dr. Sanjivi's group is extremely critical of the lack of quick transport facilities in case of emergencies in rural areas. It is working on a project under which different types of transport—tractors, trailers, bullock-carts, etc.,—are being tried out as quick conveyance to referral hospitals.

The Society for Voluntary Health Services has been steadily growing since its beginning in 1958. The health co-operative scheme has been successfully implemented in Adyar, Madras and has been endorsed by many groups in the country. It has received high praise from visitors. The Tamil Nadu government has accepted Dr. Sanjivi's scheme of health co-operatives in principle. There are 384 primary health centres covering the state and it is good that these PHCs will work with these 7,000 mini health centres, most of which have yet to be set up, says a senior colleague of Dr. Sanjivi. Only 150 MHCs are functioning at the moment. But of those, Dr. Sanjivi's VHS runs only four: the others are functioning through different voluntary agencies.

This success has not prevented the scheme from facing criticism. Several voluntary field workers find the scheme too doctor-oriented. They feel not only that availability of a doctor within or near a village retards the acceptance of local paramedical workers—and using para-medical workers could reduce the cost of health services—but also that doctors generally do not exhibit Dr. Sanjivi's level of sincerity towards rural development. These doctors tend to treat their position only as job opportunities.

Dr. Sanjivi does not agree with this line of argument. He believes it is possible to orient city-bred doctors toward rural welfare given the right kind of training. He refers nostalgically to his student days in the British period when serving in villages and tribal communities was a compulsory part of the medical curriculum. "Three years of vocational service in villages should be made compulsory," he asserts.

It is clear that for the success of the scheme the right perspective has to be consciously inculcated among the team of volunteers. Without this perspective the venture might not continue to function with the same degree of commitment as it does under Dr. Sanjivi's leadership.

Indian Express, Sept. 22.

Every Impairment Need not Become a Disability

RAZIA ISHMAIL

ONE child in every 10 is born with an impairment —or acquires it early in life—and becomes blind, deaf, mentally retarded or physically limited. Because such children's special needs are not detected, and because rehabilitation services are scarce and inadequate, they become disabled, experiencing difficulty in moving, eating, seeing, speaking, hearing or learning. These limitations can also prevent them from being self-reliant, useful and productive members of society. Then they are handicapped.

If that one child in ten receives helpful treatment, education and training when it is most needed, every impairment need not become a disability—and every disability need not become a handicap, and a painful burden for both the individual and the community. But in today's world, that child is still caught in a cruel web of misunderstanding, superstition and neglect.

The most challenging aspect of this problem lies in the fact that much of this severe disability could be prevented. The main causes of impairments and subsequent disabilities are inadequate nutrition, difficulties at birth, preventible diseases, infections and accidents. There is ignorance not only about the causes, but also about prevention and possibilities for rehabilitation. This is also why society turns away from the disabled instead of helping them by generating needed services and opportunities. Recognising this global problem, the United Nations has declared 1981 as the International Year of the disabled Persons. It is a year for governments to take stock of the challenge and make plans to meet it. In India, we do not know the dimensions of disability yet. The 1981 Census has broken new ground by counting the severely disabled. Sample surveys will provide additional information to help policy-makers plan services.

India already had incentive schemes to encourage employment of the disabled. In 1980, the Union Government formulated a National Plan of Action that will improve prospects of prevention, rehabilitation and assimilation.

Towards this end, the 1981-82 Budget already includes encouraging concession and subsidies for the disabled.

But the future—both for prevention and for assistance—will depend on how we regard the disabled. Children or adults, they are people. If they have problems, they also have potential. What they deserve is a fair deal, and 1981 gives us an opportunity to offer them just this.

The Church in Chotanagpur Archdiocese of Ranchi

Fr. Nicholas Kerketta

Chotanagpur plateau, the southern belt of Bihar State, consists of vast ranges of mountains and forests and covers an area of 70,335 sq. miles. In contrast to the smooth Gangetic plains of north Bihar, the Chotanagpur plateau is hilly and its paddy fields give an impression of endless stairs. The highest point of the plateau is 3,750 ft above sea-level known as Netrahat. Ranchi, the capital town of this region, is situated at 2,120 ft. above sea-level.

Till recently, Ranchi was hardly known to the rest of Inia. Today however, with its gigantic industrial set-up of H.E.C, H.S.L., MECON C.C.L. etc., Ranchi is known to many. However, it took almost a century to reach this stage. In 1842 a certain Captain Ousely acquired land from the Maharaja of Chotanagpur and built an imposing edifice, today known as the office of the Commissioner of Chotanagpur. Its agreeable climate and fascinating panorama of mountains and valleys of forests and peaceful environment allured the British Government officials and civilians. In 1844 Captain Wilkinson of the British Indian Army shifted his Eastern Administrative headquarters to Ranchi, then known as Kissanpur. Since then a number of military regiments have settled down here permanently.

The initial step towards industrialisation may be credited to Mr Standord, a civilian, who in 1862 initiated tea plantation in a village called Hotwar. Very soon the tea-processing factories indicated the advent of industrial era. The next phase of industrialisation was realised when the lime and bauxite mines of Lohardaga were dug and transported by railway to the aluminium factory of Muri. The latest developments of industrialisation came up only after independence. Today, Ranchi has become a meeting ground of technicians from abroad and Indian nationals hailing from all over the country. Ranchi has expanded and attained its present status rather too fast. It covers the area of 18 sq. miles with a population of 5 lakhs. The rapid growth in area and population has given birth to many acute problems like unemployment, lack of proper sanitation, housing and transportation.

Christianity

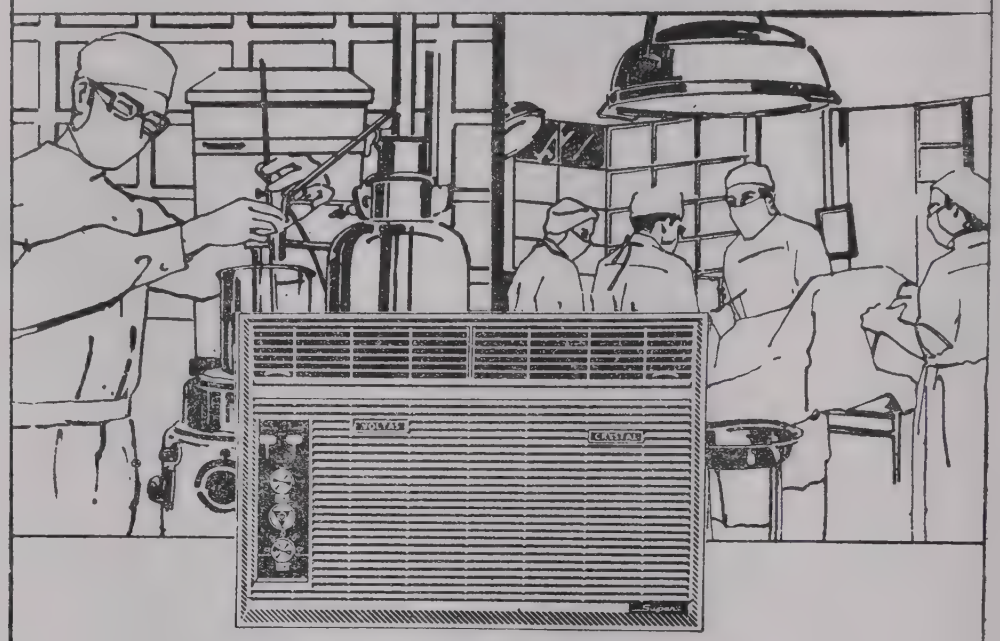
Christianity, in its own way, has played a significant role and contributed to the history of Chotanagpur. Its participation in the development of Ranchi and its adjoining regions may not be ignored.

Christianity was brought to Chotanagpur by the German Lutheran missionaries, who arrived in Ranchi in 1845. Six years later, in 1851, they laid the foundation-stone of the first Christian (Lutheran) Church in the Gossner compound.

Other Protestant missionaries arrived in Ranchi in 1870 and the foundation stone of the present St. Paul Cathedral was laid by Colonel Dalton.

The Catholic missionaries of Chotanagpur were the last to arrive. The entire region of the present the West Bengal, Bihar and Orissa states and part of the Madhya Pradesh, then belonged to the Archdiocese of Calcutta. The Jesuits of the English Province, were entrusted with the care of the needs of the faithful. In 1858 the Belgian Jesuits were invited to collaborate in the vineyard. An enthusiastic Belgian Jesuit, Fr. Auguste Stockman, took the initiative of travelling by bullock-cart from Midnapur (West Bengal) and after a difficult journey of a fortnight, landed in Chaibasa—now in the Jamshedpur diocese—in November, 1868. He met the Ho and Munda tribes of the region. His first converts were Mundas. In spite of hardships and inconveniences,

The healing touch...



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he continued the work of spreading the faith. In 1873 he settled down at TORPA, which soon became the centre of evangelisation.

From 1877 the missionaries started visiting Doranda (Ranchi) as military chaplains. In 1884 the coffee garden along Purulia Road was acquired and Manresa House was built. Thus Ranchi became the Catholic headquarter of Chotanagpur. Its Cathedral of Immaculate Conception was, however, built and consecrated only in 1909.

Growth and Expansion of the Catholic Church

After Auguste Stockman, zealous missionaries like Constant Lievens (1885) and Fr. Cardon s.j. gave a boost to the work of evangelisation. Now not only the Mundas but the Kharia and Oraon tribes came forward to embrace Christianity in great number. Eventually, in 1927, the Ranchi Tribal Mission was separated from the Calcutta Archdiocese and the new diocese of Ranchi was created. Rt. Rev. Louis Van Hoeck s.j. the then bishop of Patna, became the first bishop of Ranchi. In the course of time, the S.V.D. Fathers from Germany, and American and Australian Jesuits were invited to share the burden of evangelisation. Ranchi mission had grown to maturity. The Tribal church at Ranchi gave birth to the sister-churches, the dioceses of Sambalpur (Rourkela), Raygarh-Ambikapur, Jamshedpur and Daltonganj—Hazaribagh.

Education

Realising that Ranchi is not only an industrial centre but also an important educational pivot and a resources of Christianity and develepment of the region it may be of interest to learn the impact of this local church.

Right from the beginning, the missionaries of this area were conscious of the needs and aspirations of their faithful. The faith embraced by the converts would remain superficial, and their labour fruitless if it was not nourished and deepened systematically. The need of regular catechesis inspired the missionaries to open primary and middle schools in all the mission stations. Wherever possible, the village catechist was entrusted with the task of looking after the village primary school and Sunday prayer services. The Catechists themselves were regularly instructed and guided to foster the spread of the faith. Every Sunday people would pray for the spread of the Catholic faith. The parents were encouraged to send their children to school. Boarding facilities were given to the students coming from distant villages. Gradually, the high schools and colleges were the felt needs of the people. The missionary bishop, Rt. Rev. Oscar Sevrin, encouraged the people to contribute their share in the form of land, money, labour and personnel. The whole educational system was organised and updated. Today the Archdiocese of Ranchi alone has 4 colleges, 77 high schools and 380 primary schools.

Socio-Economic Developments

The next area of achievement is that of socio-economic and cultural development. The missionaries were amazed to discover that the tribals were harassed by the Rajas, Zamindars, Mahajans and the rich of the locality. Land alienation, and various forms of exploitation and injustice prevailed. The tribals, illiterate and backward as they were, had nobody to defend their rights. There was no one to give them guidance.

A '*farseeing*' missionary, Fr. J. B. Hofmann s. j. in collaboration with the British government, codified the Chotanagpur Tenancy Act and thus secured the rights of the tribals to their land property.

Further, he established a Chotanagpur Catholic Mission Cooperative Credit Society. Its primary aim was to help the farmers with loans to redeem their mortgaged lands, purchase bullocks, improve their fields and thus redress their economic miseries. The cooperative society has flourished and its Agricultural Extention today answers the need of ongoing education of village farmers and training of village level workers known as Kamdars. Every Village Level Worker undergoes a training of two years at the A.T.C. Namkum. Every parish is expected to have a set of these trained personnel. The cooperative Bank looks after training-scholarships and salaries.

The Xavier Institute of Social Service is one of the training institutes which was started in July 1955. Its main objective was social service. Today 25 years later it has grown into a tribal development oriented institution. Its primary focus is on integral rural development. It also prepares young men and women for work as change-agents in industries. Its research and training programmes attuned to the rural needs have rendered commendable service to the educated yonth.

Grihini School

A sort of non-formal education imparted to the illiterate girls of marriageable age through what is called the Grihini school. All the Catholic girls, with little or no education whatsoever are offered this opportunity of specific training. The Grihini course

lasts six to ten months and covers the following subjects. Mother and Child; Home Nursing; First Aid; Knitting and Sewing; Home Mangement; Means of increasing Family Income and Budgeting.

There are 12 Grihini schools functioning in the Archdiocese. The trained sisters of different congregations have taken this apostolate with zeal and dedication. "We feel convinced that if we want to improve our villages and village life, to fill our simple folk with a new life and a new hope, to bring a new spirit to so many dull and dreary villages, we must first of all educate the mothers of the families, the Grihinis or the "mistress" of the house. It is only then that we shall be able to strengthen the village life and make the family really the foundation and basis of society in general and of the Catholic Church in particular." These are the words of the Archbishop D. Kerketta s. j. who has always encouraged the all-round development of his flock.

Medical Care

The Tribes of Chotonagpur plateau have their own prarmacopoeia. Every householder has some idea of the curative power of drugs, obtainable from root, bark and leaf. A snake bite, fever etc. are most ordinary cases of the treatment which a householder is expected to cope with. In more difficult cases the village *BAID* or harbalist who is adept in diognosis, prescribes the medicine. In former days a catechist was expected to be specialised in this type of service. He would pray over the sick and administer medicament.

In the early days of missionary strategy there were no hospitals and dispensaries. The missionaries kept the most ordinary medicines against cholera, malaria, snake bite and so forth. For quite some time the dispensary of Kamdara run by the Protestants catered to the needs of the sick and wounded. The government hospitals and dispensaries were available only in district and sub-divisional headquarters.

The apostolate of medical service was undertaken by the Ursulines in the Government Sadar Hospital at Ranchi for many years. Later due to difficult service conditions, this had to be abandoned.

The first Catholic hospital of Ranchi Archdiocese was started in Mandar on March 19, 1947. The sisters of the Society of Catholic Medical Missionaries took up the much needed apostolate. Since then the hospital has rendered marvellous service to the people of the region. The priests and nuns of the Archdiocese have profited no less. The Holy Family Hospital of Mandar soon realised the need of a wing for training of nurses. Now every year some 100 nurses are trained for the medical services in hospitals and dispensaries of the region.

The latest development in the field of medical service of Mandar hospital is the School Health Programme in 69 villages of Mandar Block. The main activities undertaken are the following:–

(1) Immunisation (2) Nutrition (3) Health Education (4) Achievement motivation (5) Leadership training (6) Adult education (7) Disease Control Programme, such as T.B. programme, Leprosy, and malaria, etc.

The Ursula Hospital of Lohardaga, started in 1966 renders yet another specific service. It has an A.N.M. Nurse Training section which caters to the needs of our own dispensaries in the archdiocese.

Health is one of the basic needs of man. It is to be taken as one of the components of the overall development of the community. Inspired by this basic understanding, the Archdiocese launched the Ranchi Archdiocese Health Service in 1978. A team of 5 sisters from different congregations conduct training courses regularly at different centres. The trainees are selected and deputed by the village elders, called *Panchas*. These are mature men and women with a sense of responsibility and service. The number of hospitals and dispensaries are the following:

Hospitals	Beds	Dispensaries
8	460	61

The following are the names of congregations of the Archdiocese working in hospitals and dispensaries:

(1) Societies of Catholic Medical Missionaries
(2) Religious of St. Ursula (Ursulines)
(3) Srs. of Charity of Jesus and Mary
(4) Srs. of Sacred Heart
(5) Srs. of Charity of St. Anne (Andaman)
(6) Samaritan Sisters
(7) Daughters of St. Anne
(8) Missionary Srs. of the Queen of Apostles
(9) Missionary Srs. of Charity (Mother Teresa)

In 34 years much has been done. Obviously also, much more still remains to be achieved in the years to come □

THE HOME FOR THE DISABLED, SECUNDERABAD

"THE inmates are happy and cheerful in spite of their disabilities". This is the remark of the visitors of the Home for the Disabled at Bansilalpet, Secunderabad. There are about 300 inmates who are afflicted with various types of disabilities. Some are lame, deaf, dumb and blind; others are mentally retarded, including a few old people.

This Home for the Disabled was started in 1933 by a group of social workers belonging to different religions. The aims are as follows :

a) To offer a Home for the Blind, the maimed, the lame and other disabled and destitute persons and afford shelter to them and provide them with food, clothing and other necessities.

SPORTS & GAMES

Sr. Pietrina with a handicapped boy.

b) To receive destitute persons sent from Hospital as incurable or beyond treatment and take care of them till their last days.
c) To work for the Social, Moral and Spiritual uplift of such persons without distinction of caste, creed, colour, age, sex or locality they come from.

At the request of the committee, the Congregation of St. Ann of Providence has provided Sisters to look after the inmates. The day-to-day administration of the Home is entrusted to the Sisters. At the moment Sr. Pietrina is the Sister-in-charge of the Home and Sr. Esther is her assistant. Sr. Pietrina is the soul of the Home and she has an extraordinary charism for this type of apostolate. Under her care the Institution has developed to be a real home for the disabled.

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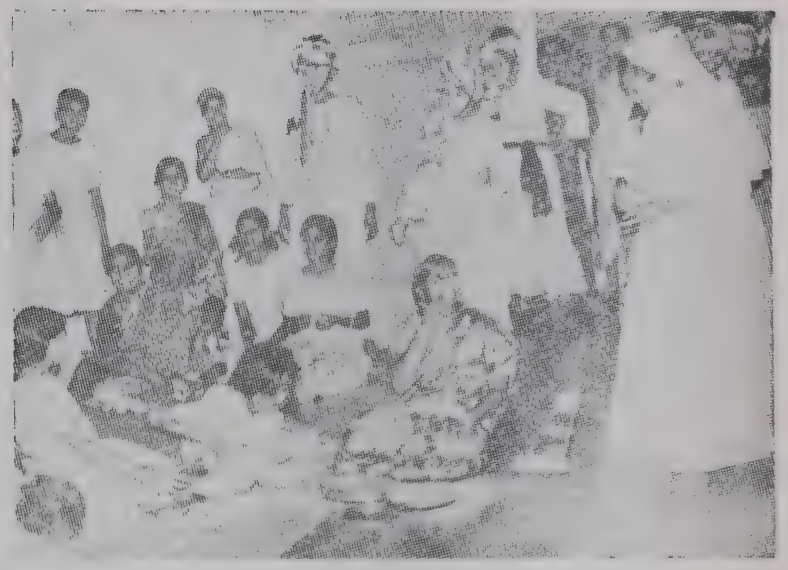
Girls at needle work.



A scene from a cultural programme.

The home had many small buildings put up by local people at its inception when there were only 35 inmates. By 1970 the number increased to 200 and hence we had to think of new buildings big enough to accommodate all the people. From 1970 onwards we started to renew our accomodation facilities. We are happy to record that Misereor has paid fully for one building and partially for another building. Help the Aged, London, helped partially for another building; Caritas of Netherlands helped for another building; Propaganda Fide helped with $ 2000 for a community hall now used for mass and public functions. Usually the buildings consist of a long hall with a verandha. It is their living room and dormitory. The inmate usually sleep on the floor. The old people are provided with a cot.

Maintenance of the home

The home is maintained by charities. The government of India gives an annual grant of Rs. 10,000/-. We have built a few shops on the periphery of the compound and they are rented out. For the major share of expenses, we depend upon our friends and benefactors. Somehow the Lord had been very provident to us. Sisters Pietrina is like Mother Theresa of our locality and whenever we are short of food, she will go out to beg for food from one or other benefactors and her efforts were never in vain.

Mode of running the home

The running of the Home is so arranged that the inmates help each other mutually. As soon as a new one is admitted, he is entrusted to the care of another according to his/her disability. Thus those who are mentally alright look after those who are mentally retarded. They help each other in washing, eating and playing. They also maintain the home. Some of them assist in the kitchen.

A lame Girl at work.

Her handicrafts are not handicapped.

The Home is known for it cleanliness. Any visitor comes at any time will find the home clean

and neat. This is to the credit of Sisters who have trained them thus.

The inmates spend time in doing some work or the other. Those who are mentally alright are engaged in works such as embroidery, gardening, looking after inmates, taking them to hospital when sick, etc. They also train themselves in cultural programmes. When visitors come here, they can also display their skill and make them realise that even though disabled, they are capable of doing things like other normal people.

We have also here a few girls who are normal and who are relative of one of the inmates. They are sent to school. They are accepted here becaues of the poor condition of their homes.

Thus the Home for the disabled is run under the motherly care of Sr. Pietrina and her colleague. She has the heart to love every inmate genuinely and that is the secret of their happiness and the asset of the Home. Feeling wanted and loved removes the handicap of the meaninglessness of life. Thus the Home, though has physically disabled people, entertains a healthy atmosphere. The Home for the Disabled is a real home where love and sacrifice never lacks.

DON'T QUIT

When things go wrong, as they sometimes will,
When the road you're trudging seem all uphill,
When the funds are low and the debts are high,
And you want to smile, but you have to sigh,
When care is pressing you down a bit-
Rest if you must, but don't you quit.

Life is queer with its twists and turns,
As every one of us sometimes learns,
And many a fellow turns about
When he might have won had he stuck it out,
Don't give up though the pace seems slow-
You may succeed with another blow.

Often the goal is nearer than
It seems to a faint and faltering man;
Often the struggler has given up
When he might have captured the victor's cup;
And he learned too late when the night came down,
How close he was to the golden crown.

Success is failure turned inside out-
The silver tint of the clouds of doubt,
And you never can tell how close you are,
It might be near when it seems afar;
So stick to the fight when you're hardest hit-
It's when things seem worst that you must not quit.

—Author Unknown

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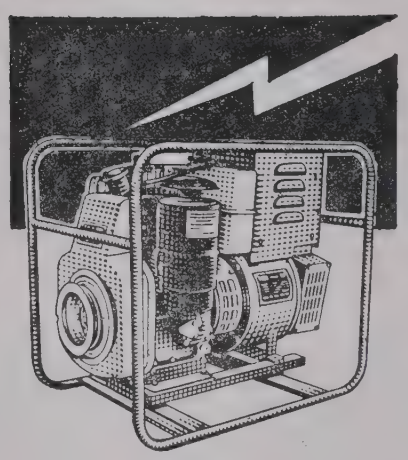

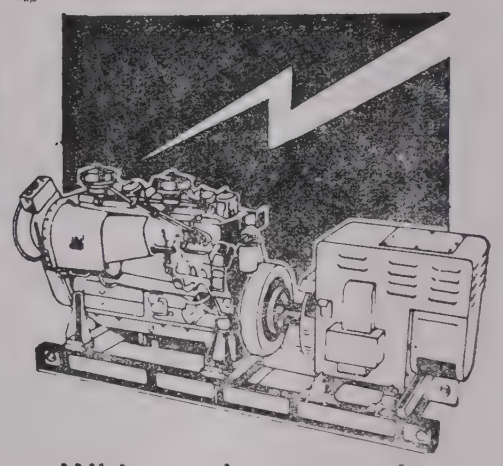

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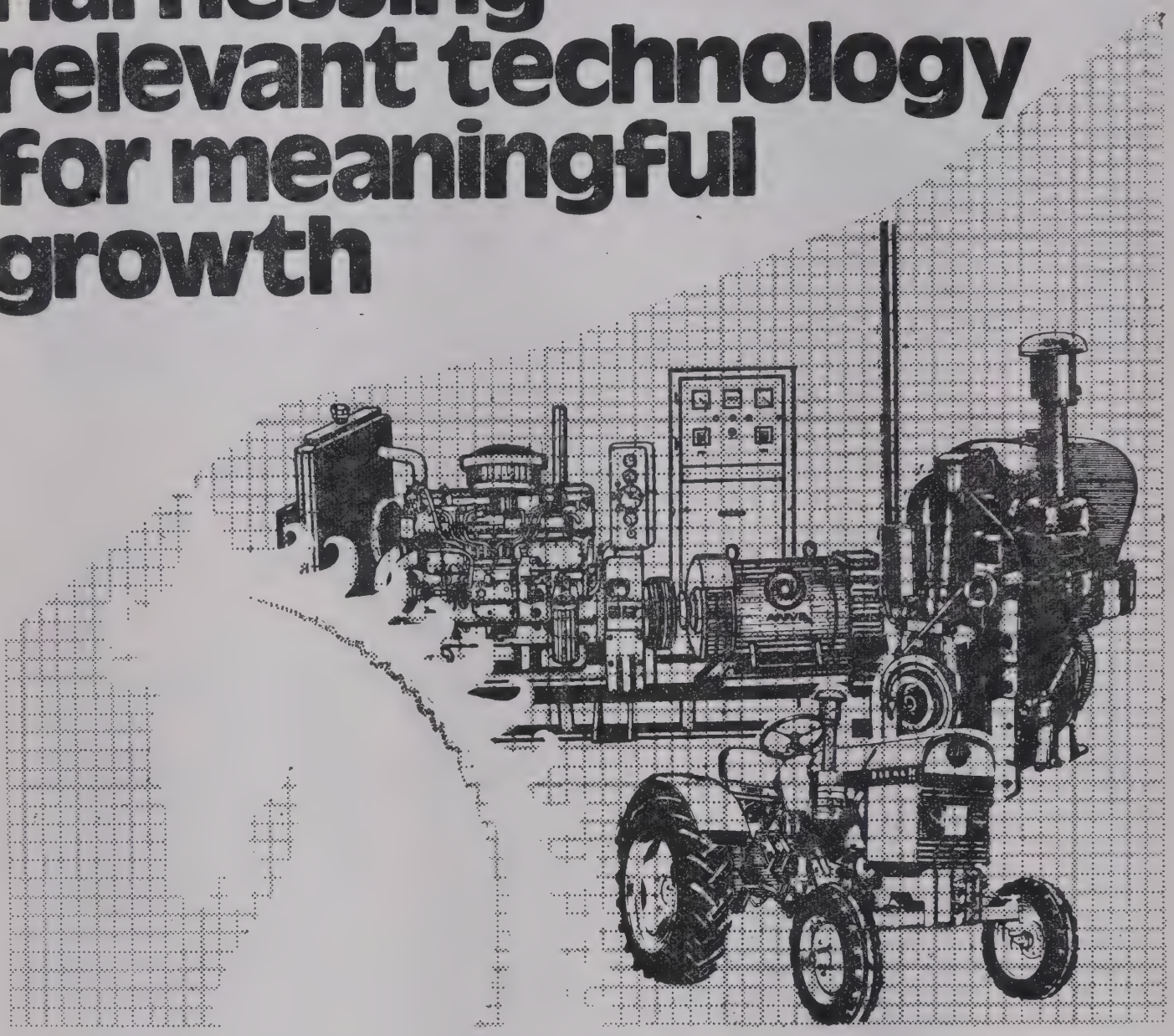

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I'll take what Father takes

The board was filled with choicest fare,
The guests sat down to dine;

Some called for bitter, some for stout,
And some for rosy wine.

Among this joyful company,
A modest youth appeared;

Scarce sixteen summers had he seen,
No specious share he feared.

An empty glass before the youth,
Soon drew the waiter near.

"What will you have, Sir ?" he inquired,
"Stout, bitter-mild or clear ?

We have rich supplies of foreign port,
We have first-class wine and cakes."

The youth with guileless look replied,
"I'll take what Father takes."

Swift as an arrow went the words,
Into his father's ears;

And soon a conflict deep and strong,
Awoke terrific fears.

"Have I not seen the strongest fall,
The fairest led astray ?

And shall I on my only son,
Bestow a curse this day ?

"No—heaven forbid ? Here, waiter, bring,
Bright water pure to me.

My son shall take what Father takes-
Water my drink shall be."

—Author Unknown

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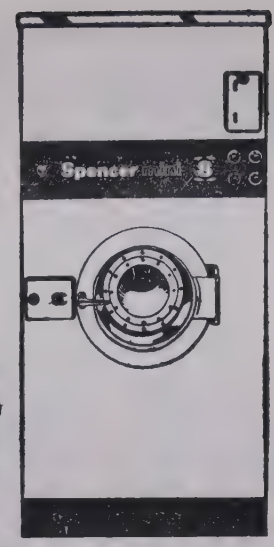

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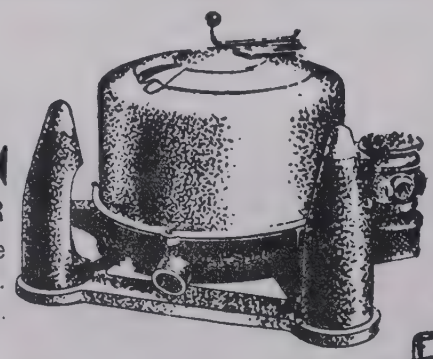

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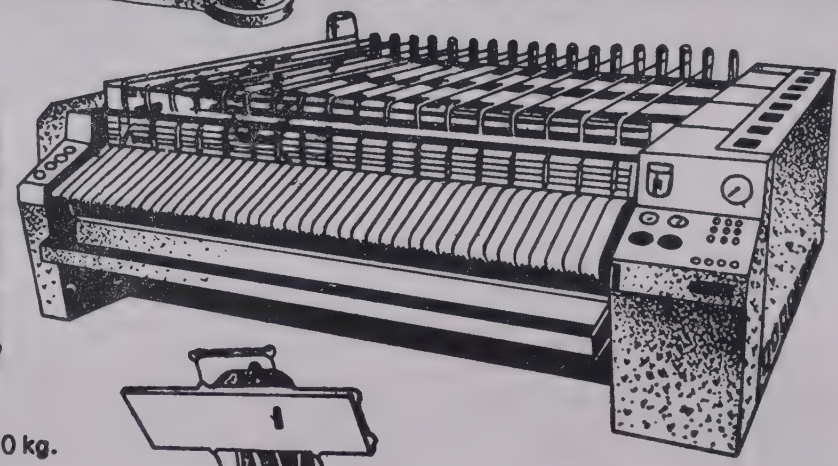

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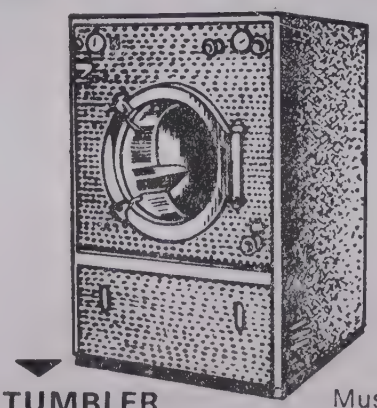

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38TH NATIONAL HOSPITAL CONVENTION AND EXHIBITION

OCTOBER 23-26, 1981

Nirmala College, Ranchi, Bihar

THEME : ''MEETING DISABILITIES—A CHALLENGE''

Programme

Friday, Oct. 23, 1981

9.30 a.m. onwards	:	**Registration**—Nirmala College, Ranchi
11.00 a.m.	:	INAUGURAL SESSION
11.00 a.m.	:	**Prayer**
11.05 a.m.	:	**Welcome**: Most Rev. Pius Kerketta,sj, Archbishop of Ranchi.
	:	Fr. Mathew Chakkalakal, President, CHAI.
11.20 a.m.	:	**Inaugural Address**: Most Rev. Agostino Cacciavillan.
11.35 a.m.	:	**Theme Presentation**: 'Meeting Disabilities—A Challenge' Fr. John Vattamattom, SVD., Executive Director, CHAI.
11.45 a.m.	:	**Presidential Address** : His Excellency Dr. A.R. Kidwai, Governor of Bihar.
12.00 noon	:	**Releasing of the Convention Souvenir**: Most Rev. Benedict Mar Gregorios, **O.I.C.** Archbishop of Trivandrum and Chairman of the CBCI Commission for Health.
12.15 p.m.	:	**Speech**: Dr. Umeshwar Prasad Verma, Minister for Health, Govt. of Bihar.
12.30 p.m.	:	**Vote of Thanks**: Dr. (Miss) Brigeetha V.V., Vice-President, CHAI.
12.40 p.m.		**Opening of the Exhibition**: Dr. Umeshwar Prasad, Verma, Health Minister.
1.00 p.m.	:	**Buffet Lunch** : (For all registered delegates and special invitees)
4.00 p.m.	:	**Tea**
5.00 p.m.	:	**Concelebrated Holy Mass** at Convention Hall.
	:	**Main Celebrant**: Most Rev. Agostino Cacciavillan, Apostolic Pro-Nuncio.
		Homily: Most Rev. Benedict Mar. Gregorios, oic,
6.30 p.m.	:	**Discussion** on Centralised system of purchase and supply of medicines and other medical needs **Chairman**: Fr M. Vd. Bogaert, XISS, Ranchi and Mr. C.T. Thomas, Head CPS of CHAI to lead.
7.30 p.m.	:	**Supper**

Saturday, Oct. 24, 1981

7.00 a.m.		**Holy Mass**
8.00 a.m.	:	**Breakfast**
9.00 a.m.	:	I SESSION:
		Chairman: Fr. James S. Tong s.j., Executive Director, Voluntary Health Association of India.
		Key Note Address: Dr. C.M. Francis, Dean, St. John's Medical College, Bangalore.
10.30 a.m.	:	**Coffee Break**
11.00 a.m.		II SESSION: **Chairman**: Bishop Abraham Viruthakulangara, Bishop of Khandwa and member, CBCI Commission for Health.
		Talk : Problems and solution of Orthopaedically Handicapped in Bihar : Shri Bhagwat Murmu, Santal Paharia Seva Mandal, Bihar.
12.30 p.m.		**Lunch** (After lunch, visit to Exhibition)
3.00 p.m.		III SESSION: **Group Discussion**
4.00 p.m.		**Tea**
4.30 p.m.		IV SESSION: **Panel Discussion**
		Theme: Community Health Programme for integrated Development.
		Moderator: Sr. Isabella Mary, Assissi Institute for Community Development, Byrathi, Bangalore.
		Participants: Representatives from various groups participating in Community Health Exhibition. (After the session, visit to exhibition)
7.30 p.m.		**Supper**
8.30 p.m.		**Talk and demonstration on low cost diet**: Sr. Dolores Kannampuzha, Medical Mission Sisters, Kottayam, Kerala.

Sunday October 25, 1981

7.00 a.m.	:	**Holy Mass**
8.00 a. m.	:	**Breakfast**
9.00 a.m.	:	I SESSION
	:	**Chairman**: Sr. Dr. Luka Kolencherry, Mercy Hospital, Poreyahat, Bihar.
	:	**Talk**: Role of Low Cost Medicines in Health Care: Dr. Daniel Isaac, General Secretary, Christian Medical Association of India, Bangalore.
10.30 a.m.	:	**Coffee Break**
11.00 a.m.	:	II SESSION: **Group Discussion** (Region wise)
12.30 p.m.	:	**Lunch** (and, visit to Exhibition)
3.00 p.m.	:	III SESSION: **Group Discussion**
4.00 p.m.	:	**Tea**

4.30 p.m.	:	**Plenary Session: Chairman**: Dr. S. Gunasekharan Vaz, CMC, Vellore. Presentation of group reports followed by discussion.
7.30 p.m.	:	**Supper**
8.30 p.m.	:	**Cultural Programme**: —Sr. Jacintha and her group, Ranchi.

Monday, October 26, 1981.

8.00 a.m.	**Breakfast**
9.00 a.m.	**General Body Meeting: Chairman**: Fr. Mathew Chakkalakal President, CHAI. Introduction by Chairman.
9.05 a.m.	**Report of the Annual General Body Meeting of CHAI, 1980**,—Sr. Sara Kaithathara, Secretary, CHAI.
9.15 a.m	**Annual Report**: Fr. John Vattamattom, SVD., Executive Director, CHAI,
9.25 a.m.	**Report of CPS**: Mr. C. T. Thomas, Head, CPS.
9.45 a.m.	**Financial Report**: Fr. P. Remigius, Treasurer, CHAI.
10.00 a.m.	**Presentation and Approval of resolutions and amendments by Chairman.**
10.30 a.m.	**Coffee break**
10.45 a.m.	**Election of office bearers**
12.15 p.m.	**Vote of thanks**—by the Executive Director
12.30 p.m.	**Lunch**
1.30 p.m.	**Leaving for Mandar**
3.00 p.m.	**Concelebrated Holy Mass in Adivasi style**; at Holy Family Hospital premises, Mandar. **Main Celebrant**: Most Rev. Pius Kerketta, sj, Archbishop of Ranchi.
4.30 p.m.	**Tea and visit to Holy Family Hospital, Mandar.**
5.30 p.m.	**Cultural Programme**
7.30 p.m.	**Leaving for Ranchi**
9.00 p.m.	**Supper**: (Nirmala College)

Tuesday, October 27, 1981.

7.00 a.m.	**Holy Mass**
8.00 a.m.	Breakfast

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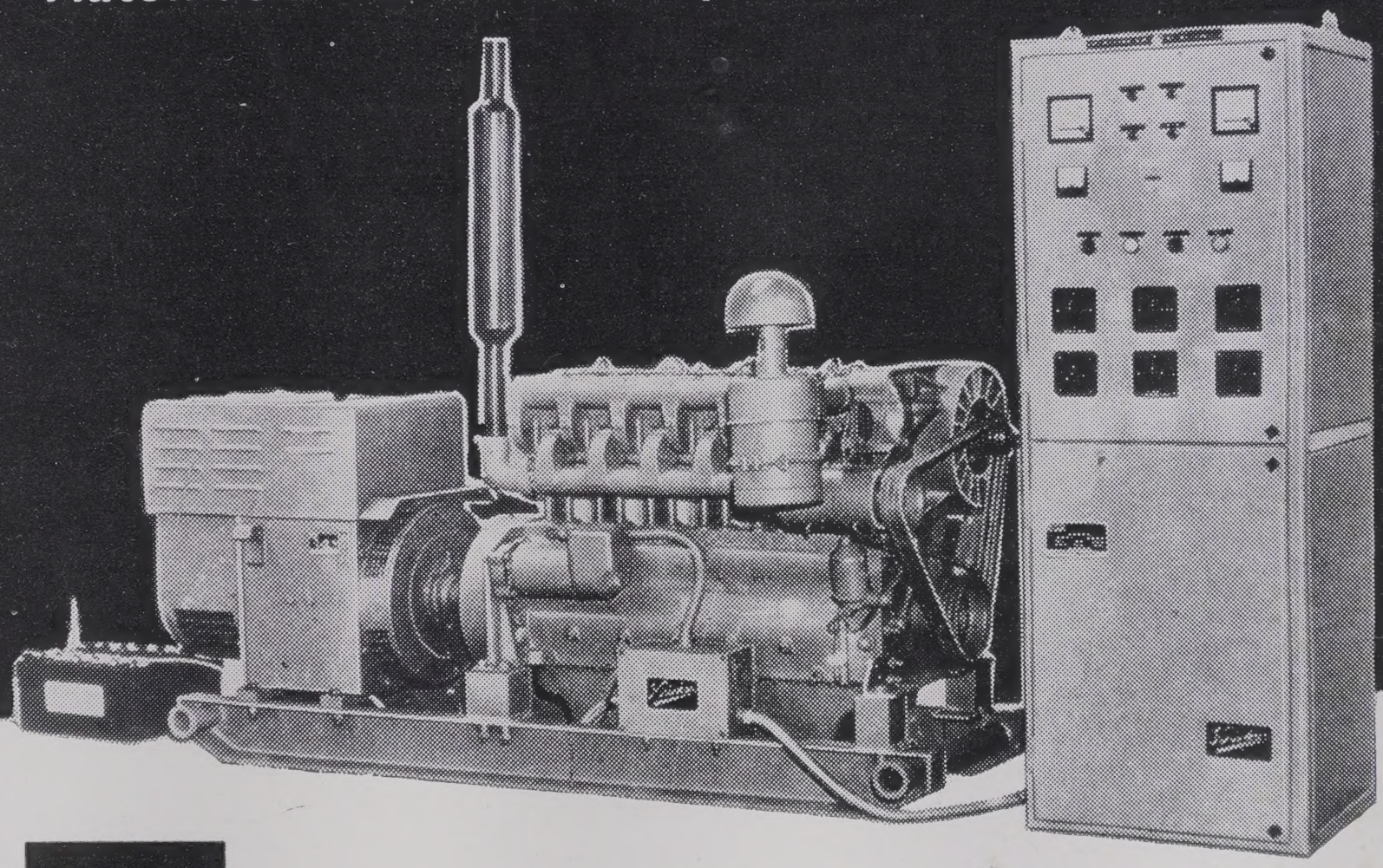

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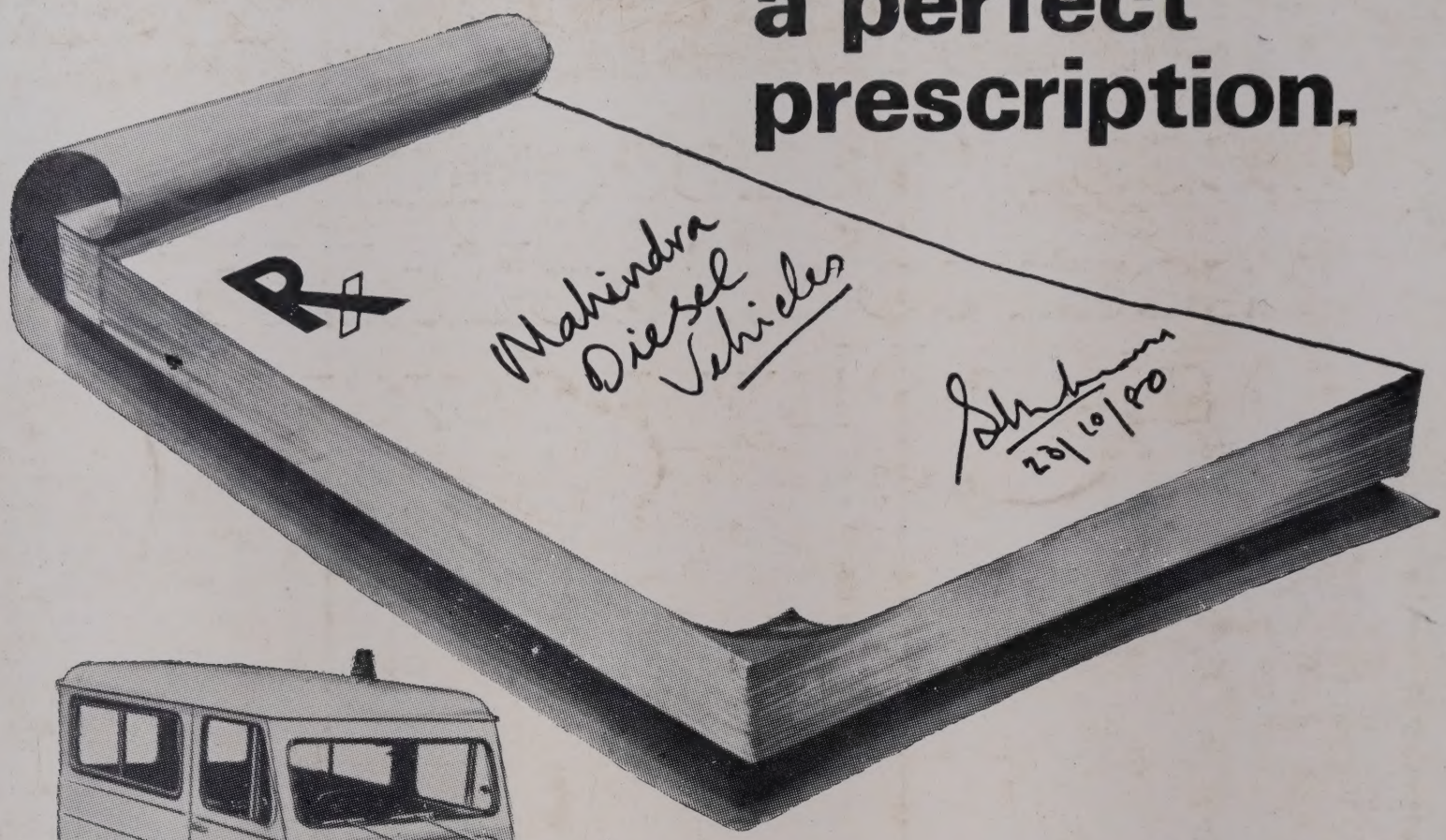

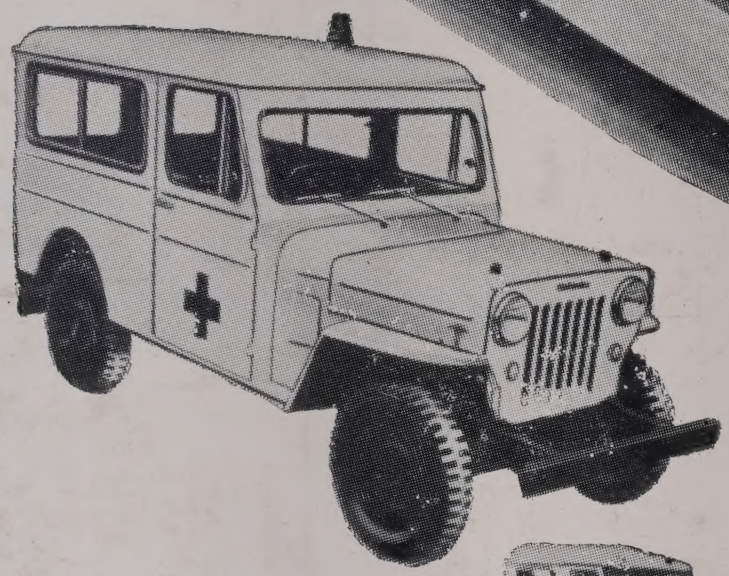

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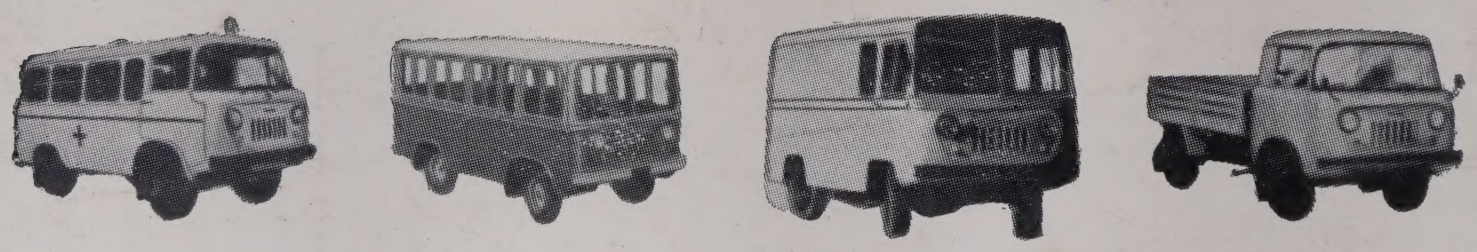

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